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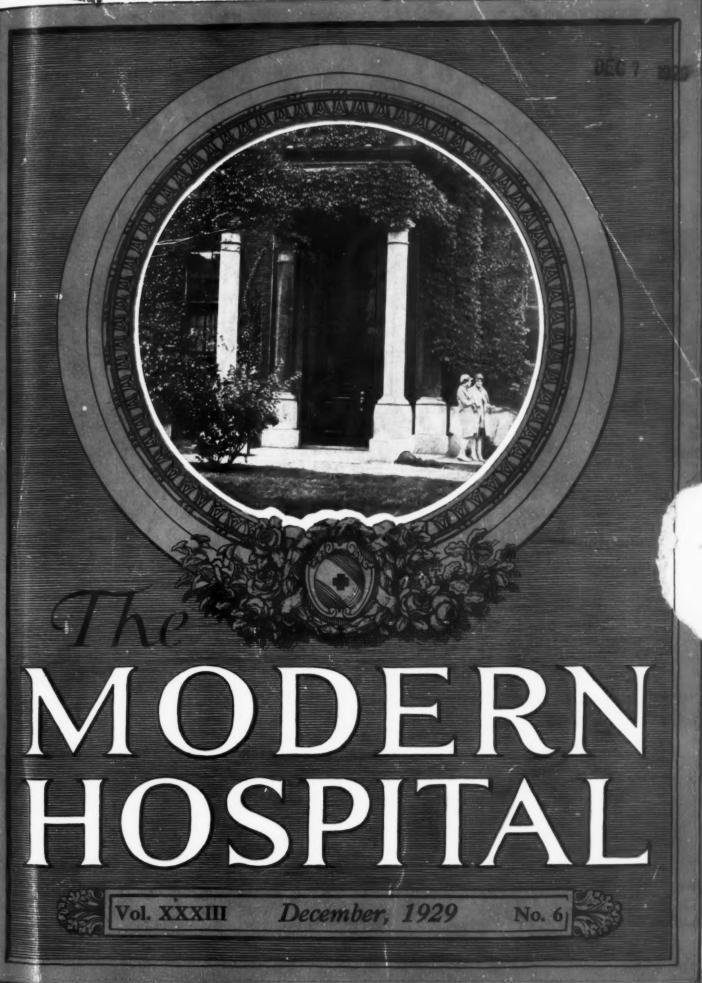
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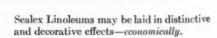
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CONTENTS

For December, 1929

COVER PAGE-Entrance to Maine General Hospital, Portland, Me.

ORIGINAL ARTICLES

nctive

ond

	Competent Direction Will Ensure Adequate Laboratory Service Frank W. Hartman, M.D.	45
	Saginaw Hospital Plans for Its Small Patients	53
	Radiographic Film Hazards and How They May Be Eliminated	57
	Careful Hospital Planning Promotes Economical Administration	61
	Cost of Hospital Service as Viewed by a Hospital Executive	69
	A Modern Laundry Plant That Serves a 700-Bed Hospital	78
	How to Maintain Efficient Case Records	77
	A Nurses' Home Equipped for Social and Residential Purposes	79
	Hospital Records and Reports and What They Should Show P. G. Savage	83
	Advertising Occupational Therapy Ethel C. Dana	85
-	Citrus Fruit Juices—Nature's Gift to the Hospital Dietary Lulu G. Graves	87
	Keeping Patients Comfortable by Means of the Health Room	89
	Hospital Changes and Developments in Foreign Countries	92
	(Continued on page 4)	

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CONTENTS

How to Make the X-Ray Department a Financial Asset	94
The Problem of Placing the Private Duty Nurse Lucy Van Frank	118
Carrying Holiday Cheer to the Sick on the Christmas Tray Elsbeth J. Hennecke	124
The Diagnostic Clinic-Its Virtues and Its Shortcomings	130
How to Plan and Maintain a Lock and Key System	138
PRACTICAL ADMINISTRATIVE PROBLEMS	
How to Make the X-Ray Department a Financial Asset	94
EDITORIALS	
When Are Statistics Vital?	
Annual Report of Hospitals	
Misplaced Emphasis	
Ethics and Economy	101
TALKING IT OVER	102
YOUR EVERYDAY PROBLEMS	103
NEWS OF THE MONTH	106
NURSING AND THE HOSPITAL	
The Problem of Placing the Private Duty Nurse	118
DIETETICS AND INSTITUTIONAL FOOD SERVICE	
Carrying Holiday Cheer to the Sick on the Christmas Tray	124
OUT-PATIENT SERVICE	
The Diagnostic Clinic-Its Virtues and Its Shortcomings	130
HOSPITAL EQUIPMENT AND OPERATION	
How to Plan and Maintain a Lock and Key System	138
Advantages of Aluminum Chairs for Institutional Use	142
Improved Deep Fat Fryer Is Now Available	
A Portable Combination Operating Light and Moving Picture Unit	
An Automatic Gas-Steam Radiator as an Auxiliary Heating Unit	
Improved Hot Plate Has Place in the Diet Kitchen	
Improved not reace has reace in the Diet Kitchen	100

(Continued on page 6)

1929

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CONTENTS

(Continued from page 4)

MISCELLANEOUS
A Dictionary That Will Keep Us Abreast of Medical Terminology 5
The Primary Essentials in a School of Dietetics
Site of London Foundling Hospital May Become Children's Park 5
X-Ray Film Storage Problem Is Not Confined to U. S. Hospitals 6
Hospital Activities of Holland Described in Report
The Social Worker's Responsibility to the Mental Patient 7
Comparing Hospital Rates With Soaring Costs in Other Fields 7
Effective Garbage Disposal in a Hospital for the Tuberculous 7
The Duty of the General Hospital to Borderline Mental Cases 8
Righting the Injustice to the Chronically Ill 9
Concerning the Tariff on Hospital Equipment 9
A. N. A. Publishes Historical Sketch
How New Jersey Provides for Its Mental Patients
Reduced Hospital Bills, and Free Work
INDEX TO ADVERTISERS9-1
POSITIONS WANTED (CLASSIFIED ADVERTISEMENTS) 18
DOCITIONS OPEN (CLASSIFIED ADVEDTISEMENTS) 19



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A Monthly Journal Devoted to the Building, Equipment and Administration of Hospitals, Sanatoriums and Allied Institutions, and to Their Medical, Surgical and Nursing Services

Vol. XXXIII

December, 1929

No. 6

Competent Direction Will Ensure Adequate Laboratory Service*

By FRANK W. HARTMAN, M.D. Pathologist, Henry Ford Hospital, Detroit

HAT constitutes adequate laboratory service for a hospital? It is to be regretted that this question, propounded from year to year by the American College of Surgeons, cannot be answered in a single sentence. However, the essential part of the reply may be made in three words regardless of the size or location of the hospital—a competent physician director.

Adequate professional service of any type depends upon the individual or personnel sponsoring that service. When a surgical service is surveyed the measuring rod is first applied to the chief of that service and not to his hospital, his operating rooms or his instruments. The same must be said of each service of a hospital and particularly of the pathologist and the laboratory service. The physician director of the laboratory service does not necessarily devote all his time to pathology or all his time to one hospital if the latter is a small institution. No arbitrary rule regarding the size of the hospital and the pathologist's duties can be applied in all cases, but in general it may be said that any institution having such specialists as a roentgenologist, an otolaryngologist and a urologist should have a full-time pathologist or one who is available in the city at all times. The necessity for close and constant contact of the pathologist with his hospital and his department is readily appreciated when his position is defined broadly as diagnostic

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assistant, therapeutic guide, preceptor and investigator.

When the laboratory is considered as the place of operation for the pathologist and his associates instead of being regarded as the setting for a group of delicate and mysterious machines that automatically turn out the correct answer when specimens from the patient are fed into the hopper, it becomes apparent that the data obtained are of no more or less value than those coming from other specialists and their departments. This department should seldom be expected to take the initiative in making the diagnosis.

The laboratory department is one of the units of an organization cooperating to solve the patient's problem. The late Francis Peabody has said, "Good medicine does not consist in the indiscriminate application of laboratory examinations to a patient but rather in having so clear a comprehension of the probabilities and possibilities of a case as to know what tests may be expected to give information of value." pathologist as well as the clinician should have a clear comprehension of the probabilities and possibilities of the case, especially if he has had thorough experience in postmortem work. With his knowledge of the physiological basis for the laboratory tests he is logically in a position to determine what part his specialty may serve in diagnostic problems. In a number of larger institutions the pathologist now rightfully takes his place with the surgeon, the internist and the roentgenologist in such diagnostic and thera-

^{*}Read at the Hospital Standardization Conference of the American College of Surgeons, Chicago, October 14-17, 1929.

peutic problems as thyroid disorders, metabolic diseases and cancer.

In the handling of neoplastic diseases as well as in postmortem work, extensive training in gross and microscopic pathology is essentiai. Now, when so much emphasis is being laid on chemistry and immunology, with the all-inclusive term clinical pathology to cover the entire field of laboratory medicine, the pathologist must realize that he is the court of last resort in morphological pathology and that his deficiencies here will not be overlooked or condoned because of proficiency in some other branch. knowledge and exhaustive autopsy work will do much to raise the percentage of postmortems and make them one of the most stimulating as well as one of the better educational features of the hospital. Material for the weekly clinical pathological conference is for the most part drawn from the autopsy room. The pathological service of every approved hospital should arrange to present interesting specimens, fresh or attractively preserved in natural colors, along with the résumé of the protocol and correlation with clinical findings. The younger members of the staff need more detailed instruction in morphological pathology than can be obtained in the clinical pathological conference, and this is best accomplished at the autopsy table, in a review of all tissue removed surgically, and at regular meetings when both autopsy and surgical material are studied microscopically.

In his own workshop the pathologist must perfect his organization so that the work will be done accurately and promptly, whether he is the only one in the organization or whether he has a staff of associates and assistants. Experience has shown that in the larger hospital the work can advantageously be divided into morphological pathology, bacteriology, basal metabolism, chemistry, clinical microscopy and serology.

How Work May Be Divided

For the best results the physician director should take a principal part in the morphological pathology. The other divisions may be headed by medical associates or assistants who may have a Ph.D., a master's or a bachelor's degree but who should also have had a complete apprenticeship in medical laboratory procedures. When the work is so divided the senior, whether physician or assistant, should be made to feel his personal responsibility for the work in that division. The truly valuable senior is the one who maintains the closest contact with the director and never makes an important observation without calling his attention to it.

The director in turn should call in the clinicians who may be interested. On the other hand there is nothing to be gained by the director sitting at his desk and signing a huge volume of reports he has not seen or performed. This is of little or no value and slows up the service. Although the pathologist should never allow the clinician to make him sacrifice accuracy for speed in rendering his report or opinion, the time must be reduced to the minimum in all types of work. Most of the delay is not in the actual completion of the work but in the collection and delivery of the specimen and afterward in the delivery of the report which is either placed in the history or sent to the doctor in charge of the patient. Great care in making out the request tag and the avoidance of copying the report after it leaves the hands of the examiner are additional factors in prompt service. Many glaring and dangerous errors are eliminated by having the report placed directly in the history either on a form or as a sticker, for it has been demonstrated that clerical errors are more common than technical errors and the one who does the work is the one least apt to make the clerical error.

Trained Directors Are Scarce

In addition to developing the educational function of his department by keeping other staff members and other departments posted regarding current activities and new developments, the pathologist, especially in the larger institutions, must do his utmost to meet the urgent need for well trained physician directors and laboratory assistants. It is becoming increasingly difficult to find medical graduates of the desirable type who choose to take up pathology as a specialty or who have sufficient interest, knowledge and training to devote part time to the smaller hospital laboratory. In fact the medical personnel is being recruited almost entirely at the present time from two distinct groups: those who become interested and competent in laboratory procedures during the medical course, including summer work or leaves of absence, and those who have found clinical work unsatisfactory for one reason or another. The first group can be enlarged appreciably if the teaching institutions and the larger hospitals will make it a point to take these men into the laboratory and supply them with a varied and instructive program. In this connection a word of caution should be given about interrupting the medical course for too long a period and converting the potential pathologist into an underpaid dissatisfied technician.

Another opportunity to interest and instruct the young medical graduate occurs during the pe-

riod of rotation to the laboratory service, in the course of the rotating internship. Here the work should be planned with a view to giving the man greater insight into the practical side of the more complicated bacteriological, chemical and serological procedures, and their physiological importance should be pointed out. Again, if the period in the laboratory is two months or more, the doctor may become interested in a problem, either statistical or research, which may be carried on after he returns to his clinical duties. With the present limited number of medical graduates available for hospital training it is felt that the interns should not be compelled to bear the entire burden of routine urine, blood, gastric and stool work on all their patients, but should have the opportunity of doing work of this character for their patients if so inclined or instructed, the bulk of such work and the responsibility for it being. however, left to the pathologist and his staff. Under this régime the work would be handled more efficiently and economically. The intern would avoid the drudgery of such large volumes of laboratory procedures which not infrequently result in inferior work and a marked aversion to laboratory work of any kind.

How Medical Schools Can Help

Next to the necessity of attracting the proper type of medical graduate to the specialty of clinical pathology comes the necessity of proper training for the individual entering this field. Opportunities for learning straight pathology are Well organized departments in our excellent. medical schools offer yearly places for all who are seriously interested in pathology and who show even a reasonable amount of ability. In many of these departments, however, interest in surgical pathology does not compare favorably with interest in postmortem pathology. Too often the department of surgery desires to do all or the major part of the surgical pathology and calls on the pathologist only when the surgeon or his residents find a case they cannot diagnose. Such a policy often prevents the general pathologist from keeping up with his surgical pathology and precludes his teaching surgical pathology in his department. The ideal situation occurs when surgical pathology is handled by the department of pathology and the surgical staff meets with the pathological staff to review the material. Proper facilities for detailed instruction and training in clinical microscopy, bacteriology, basal metabolism, chemistry and serology are much more difficult to find, chiefly because but few of our larger hospitals have this work well organized and centralized even if they are willing to give instruction. In the medical schools where well organized departments for the teaching of clinical pathology are found, few opportunities are offered for more than a casual contact with the department of general pathology.

Hospitals Should Train Pathologists

The situation in the postgraduate medical schools is similar. Few if any combined courses are given in general pathology and clinical microscopy. For the solution of this phase of the problem, it seems that the young man must take it upon himself to go from one department to another to get his postgraduate training, at the risk of displeasing both departments, and often he does not realize the necessity or the desirability of obtaining experience in both branches of pathology. In the meantime the larger hospitals with well organized departments of pathology should open their doors for fellowships or residencies in pathology, seeing to it that periods of from three to five years are offered for well rounded training in all branches of pathology, including opportunities and encouragement for research.

After making provision for the training of the pathologist the hospital laboratory has an educational service to perform in the selection and training of the laboratory assistant, or technician as he is usually called, a term that is inadequate to designate the type of assistant the present day laboratory requires. As a concrete example, such a course as is given at the University of Minnesota seems ideal, providing as it does a liberal education along with thorough training and extensive practical experience in medical laboratory procedures and leading to a degree of B.S. in medical technology. Statistics compiled from medical schools throughout the country by Dr. W. E. King indicate that other schools have already established or will soon establish similar

Institutions not fortunate enough to have university affiliations should select only college graduates for their training courses, and then only such graduates as are vitally interested in medicine and clinical laboratory work. In the hospital laboratory, once the student is selected, the course of instruction should include approximately four months in bacteriology; four months in physiological chemistry; three months in serology; three months in clinical microscopy; two months in basal metabolism and two months in tissue technique. This instruction amounts to an apprenticeship for the pathologist, his associates and his permanent staff of senior bacteriologist, chemist and serologist, supplemented by demon-

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ct estrations, conferences and quizzes. Such a course should constitute a minimum, and provision should be made for any graduate who desires to continue his studies in one of the division laboratories as a full-time assistant.

Some would say that such education and training are wasted on a laboratory assistant or that the individual would do better to study medicine. It is perhaps advisable that the college student or college graduate go into medicine, but there are many, especially young women, who have no inclination to undertake a medical course. Again, we hear it said that such a highly trained technician will replace the pathologist taking undue responsibility and authority or may even open a private laboratory of his own. Experience shows, however, that the poorly educated or inadequately trained technician is the one who assumes too much authority and responsibility.

What Laboratory Work Should Include

The investigative activities of the hospital staff in the present day naturally center in the laboratories but they should by no means be limited to them. These activities must include not pure research alone but special or new bacteriological, chemical and toxicological problems associated with individual patients, development of new medical, surgical and laboratory appliances and methods and, lastly, statistical reviews of special types of patients or conditions. The pathologist must stimulate the spirit of research both by his example and by his assistance. In the larger laboratory it is found that the senior in each division is able to carry on some investigation and that this is a stimulus that improves the quality of the routine work. Research should be as much a part of the training for the fellowship man in the laboratory and for the transfer man from medicine or surgery as morphological pathology. Indeed these men should be made to feel that facilities for research are part of their compensation during these apprentice years. As for helping staff members outside the laboratory, the pathologist should be of material aid, providing he has done creditable investigative work himself.

The laboratory service, then, may be considered adequate if it is under the supervision of the right type of physician director because such a director will not tolerate inadequate working conditions. Standardization programs should emphasize the importance of the laboratory personnel above and beyond but not to the exclusion of buildings and equipment. The laboratory and the pathologist should be rated according to the part they play in assisting in diagnosis, treatment, education and investigation.

A Dictionary That Will Keep Us Abreast of Medical Terminology*

The fifteenth edition of the "American Illustrated Medical Dictionary" is now being distributed and boasts several noteworthy new features. This revised and enlarged edition will bring to the medical and allied professions, editors, librarians and the public the latest medical terminology. Two thousand new terms, many of which have not been published in any other dictionary, are said to be defined in this latest edition. It has been the aim of the editors to establish a standard in terminology and with this in view the entire book has been re-edited by the editorial staff of the American Medical Association under the direction of Dr. Morris Fishbein.

Included in the volume are the terminology recommended by the Society of American Bacteriologists; anatomic tables; chemical formulas; signs and symptoms of diagnostic value; a complete list of serums; a dosage and therapeutic table and many other valuable features. The table of tests which forms an important part of the book has been brought strictly up to date.

Particular attention has been paid to the historical aspect of medical terms, the name of the discoverer or originator, with date, being given in many instances, and information almost encyclopedic in character supplements many of the definitions.

Typographically the book is satisfying and many new illustrations have been added, there being included in the 1929 edition of this work 525 practical illustrations. The rapidly increasing vocabulary of medicine and the allied sciences necessitates frequent reference to such a work and the extremely flexible binding and thin stock used make the book easy and pleasant to consult.

The Primary Essentials in a School of Dietetics

What are the primary essentials in a school of dietetics?

G. W. Curtis, superintendent, Santa Barbara Cottage Hospital, Santa Barbara, Calif., enumerates them as follows in a paper presented before the education section of the California State Dietetic Association at its annual meeting:

There should be sufficient teaching material in the hospital and it must be organized in a manner to make it available to the school. There should be a staff of instructors and supervisors represented by the dietitians and the heads of various departments available to teach this material to the student dietitian. To attempt to force any set type of organization in the dietary department as a unit or in the hospital as a whole would not, in the opinion of Mr. Curtis, receive the support of the hospital field.

Mr. Curtis discusses also putting into effect the essentials and standards for a school of dietetics. First an attempt could be met to secure through legislation an official registration and inspection of schools of dietetics. Second, it is possible to have an unofficial list of approved schools of dietetics. This could be accomplished through the state association which could have its own department of registration and inspection.

^{*}The American Illustrated Medical Dictionary, edited by W. A. Newman Dorland, M.D., fifteenth edition, revised and enlarged, W. B. Saunders Company, Philadelphia.

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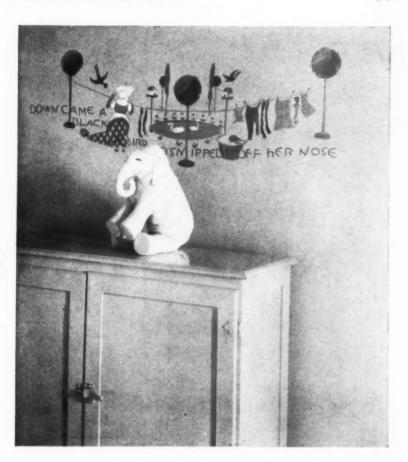
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Saginaw Hospital Plans for Its Small Patients

By KATE JACKSON HARD

Superintendent,
Saginaw General Hospital,
Saginaw, Mich.



NE of the distinctive features of the Saginaw General Hospital, Saginaw, Mich., is the children's ward, where the system of furnishings and decorations impart the homelike atmosphere so generally conceded to have a high therapeutic value, particularly in a hospital devoted to the care and treatment of children. Color has been used lavishly, giving to the rooms that bright appearance which dispels gloom and brings to little patients the playroom or nursery atmosphere.

Credit for the happy result achieved goes to the Junior Service League of Saginaw, whose members furnished and partly financed the children's ward. They raised the money for part of the equipment, they planned the decorations, they chose and painted the furniture and they decorated the walls with appropriate illustrations from children's stories.

The Saginaw General Hospital is a 150-bed hospital and the children's ward accommodates fifteen children. It is on the ground floor, and opening off the hall are two ward rooms, a bathroom, a treatment room, where minor operations, such as opening a child's ear, can be performed, an isolation room with three beds, a private room with a day bed for an adult as well as a child's bed, and a large sunny playroom with windows on three sides.

In the furnishing of the rooms, utility and convenience were kept in mind and an effort was made to gain attractiveness without sacrificing simplicity and easy sanitation. The amount of money available was limited so that everything was done as economically as possible. Except for the chaise longue, a boudoir chair and the cribs, the furniture was bought unpainted and was painted by the members of the Junior Service League.

Color Gives Bright Appearance to Rooms

The walls are all in a mellow cream color. For one ward room the color scheme is pink, for the other green. In the pink room, the chest of drawers, the chairs and cribs are a soft pink. The windows have pink checked curtains, and on the walls are familiar nursery rhymes delightfully illustrated after H. Willebeek LeMair. The other ward has green furnishings with green checked gingham curtains and a decorative border of amusing animals painted in pastel shades, such as a lavender elephant with colored trappings, and a lemon colored giraffe.

In the playroom the chaise longue and curtains are of cretonne, with a children's design in pastel colors. A cream colored child's play table has eight small chairs, four with and four without arms, one of each kind in delicate lavender, yel-



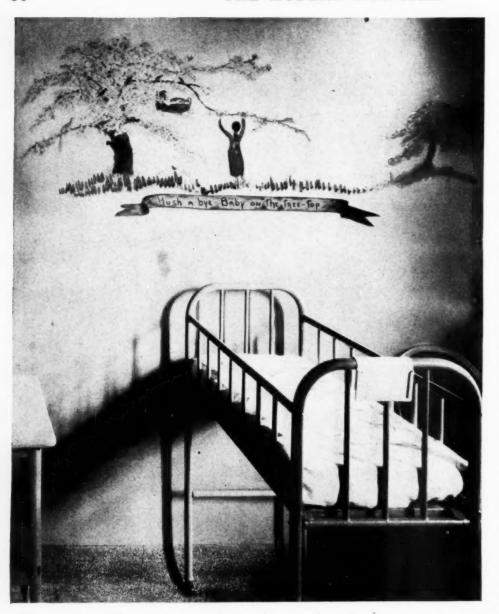
One of the many attractive features of the children's ward of the Saginaw General Hospital is a lawn where the tiny convalescents may enjoy the sunshine.





The playroom, shown above, is gay with bright cretonnes and painted furniture. Below is the private room, with facilities for a child and an adult.





Nursery rhymes illustrated in pastel colors decorate the walls of the ward room.

low, rose and blue. There is an adult's settee, a straight chair and a low rocker in Chinese red toned down with cream and there are two cream colored chests with doors, for books and toys. The braided rug is in shades of blue green. The league members made saucy stuffed animals and book ends for the play table and bought a set of little wooden blocks. Nursery rhymes illustrated after Lois Lenski in "Jack Horner's Pie," in pastel lavender, blue, pink, jonquil and green bedeck the walls.

The private room is in lavender. The dressing table, boudoir chair and maple day bed are draped in cretonne like that in the playroom and the curtains are of lavender checked gingham. Here Pooh, from A. A. Milne's "Winnie the Pooh," decorates the walls, as does Piglet the isolation room, which has apricot checked cur-

tains and apricot furniture.

On the side of every bed is hung a toy bag made of unbleached cotton, on which colored figures are appliqued.

Color notes have been introduced wherever this was possible and lend warmth and interest to every room.

Supply cupboards, the nurses' chart desk and a toy chest donated by the King's Daughters are in the corridor. A set of charming cream colored, gaily decorated children's dishes was given by the Kermiss Society, a group of twenty women who sew weekly for the hospital.

The ward is both practical and attractive. The method of furnishing it was mutually helpful to the hospital and the Junior Service League. It has given the hospital a useful new unit at a minimum expenditure of time and money. Now that the ward is completed, the league

plans to raise enough additional money to pay for all but the technical equipment and the members will amuse and work with the children.

Site of London Foundling Hospital May Become Children's Park

The London Foundling Hospital, made famous by Dickens in "Little Dorrit," has moved to the country, leaving available a large piece of ground in a part of London greatly in need of park space. Lord Rothermere has offered \$500,000 toward the purchase of this site for a children's park.

A remarkable bequest that the Foundling Hospital received two centuries ago was by the will of Handel, who left it the score of his great oratorio, The Messiah. During the lifetime of the great composer, the hospital funds were enriched by about \$50,000 through his annual rendition of his great masterpiece on the organ which he presented to this children's asylum.

Radiographic Film Hazards and How They May Be Eliminated*

By H. L. ROCKWOOD, M.D.

Health Commissioner, Cleveland

deal with problems relating to the reduction of hazards of physical injury. Hospital operation has for its main objective the professional care of invalids who, for the time being, are dependent on the hospital organization for safe conduct through a time when life and physical well-being are often at stake. Safe operation is a major subject at all times in hospital administration and includes more than ordinary attention to a long list of detailed activities affecting the care of patients.

Safeguarding the Hospital's Reputation

Standard procedures in professional care have been laid down voluntarily through the group judgment and action of hospital associations in cooperation with the American College of Physicians and the American College of Surgeons. Those standards that have been erected and put into effect have done much to bring hospital operation to the high plane it occupies to-day in the eyes of the informed public. In the city of Cleveland last year 52 per cent of all births occurred in hospitals. This was due in large part to the growing belief, and the correct belief, on the part of the public that the hospital equipped and operated under present creditable methods of operation is by far the safest place for the expectant mother. The fact that more than 40 per cent of all the deaths in Cleveland last year occurred in hospitals must not be taken to imply higher mortality rates in the hospital than elsewhere, but must rather be taken to reflect the same existing belief on the part of the public that in times of critical illness efficient and skilled care is best obtained through the hospital.

Most hospital administrators are alive to this situation, and the responsibility that they incur in safeguarding the hospital's reputation for offering its patients a type of service that presages their return to health becomes a subject of constant discussion and consideration. Hazards

that endanger life are ever present subjects in these discussions. The care and use of chemicals and drugs, the preparation of foods and the operation of elevators all constitute hazards, as do the hot water bags, the tables, the carts, the electrical appliances, the stairs, the balconies and even the beds themselves.

Under these conditions it becomes a duty of hospital organizations to consider and deal with any problem that may arise in connection with the erection of safeguards necessary to protect those who seek hospital care. This duty has arisen in connection with the handling and storage of radiographic films. The 123 lives that were lost in the Cleveland Clinic disaster of May 15 of this year and the numbers of cases of serious physical injury that resulted were caused solely by the inhalation of poisonous gases given off during the combustion by decomposition of nitrocellulose radiographic film negatives. prevent such catastrophes from happening in the future, every hospital association should consider and erect such additional safeguards in the use of radiographic films as are necessary to protect against these hazards of decomposition. The nature of the hazards of radiographic films with reference to hospital operation will be discussed here and safeguards suggested that may help to avert possible future disasters.

The Process of Film Manufacture

The hazards that exist in the use and storage of radiographic films arise chiefly from the nitric acid used in their manufacture. Photographic and motion picture films made by the same methods present the same hazards and, in commerce, quantities of materials other than films are equally capable of endangering life because the same raw materials that produce the hazard in films are used in their production.

It will be recalled that cellulose is the fibrous portion of a great many forms of vegetable and plant life. Cotton obtained from the cotton plant is a form of cellulose. When selected cotton is exposed to nitric acid in such a way as to produce

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^{*}Paper read at the meeting of The Ohio Hospital Association, Youngstown, October 9, 1929.

a chemical combination of these two substances, cellulose nitrate or nitrocellulose is formed. This product is also known as gun-cotton and as pyroxylin. The use of gun-cotton in the manufacture of explosives such as smokeless powders and some forms of dynamite is well known. When pyroxylin is dissolved in ether, collodion, which has long been used in hospital practice, is formed. Various solvents are used in preparing nitrocellulose or gun-cotton for trade purposes. In the lacquer and paint industry, in addition to solvents, pigments are added to produce some of the present day finishing coats for automobiles and other products.

In the manufacture of films from nitrocellulose, gum camphor is used as a solvent and as a so-called plasticizer. The addition of camphor gum in larger quantities is practiced in manufacturing celluloid from nitrocellulose. The camphor gives flexibility and permits molding or shaping. In film manufacture, when the film is rolled or pressed into thin transparent sheets, the light-sensitive emulsion layers are added to one or both sides of the film support composed of the mixture of the gun-cotton, the solvents and the plasticizers. Most radiographic film is now produced with the emulsion laid on each side of the film support and is known as duplitized film.

In roentgenology the film to a great extent has displaced the use of glass plates. This is due largely to greater ease in transportation as it concerns breakage and weight, better filing qualities, indestructibility and the advantage of securing better negatives through the double emulsion layers.

Nitric Acid Is Dangerous in Itself

Nitric acid, the source of most of the hazards in films, has been in itself the cause of many casualties in its manufacture and handling. Although the fumes that arise from nitric acid contain the poisonous oxides of nitrogen, these oxides are not the chief hazard created by the use of nitric acid in film manufacture nor are they the only poisonous gases that are produced when nitrocellulose films undergo the type of combustion known as decomposition. The chemical characteristics of a low temperature firing point and of a quick and practically flameless combustion that is independent of the presence of external oxygen make hazardous the substances that are acted upon by nitric acid to form nitrates. In this connection it will be recalled that saltpeter or potassium nitrate has long been used in the manufacture of explosives. Cellulose nitrate used in the manufacture of films possesses the same qualities to a high degree.

Speaking only of the nitrocellulose found in films, it may be stated that spontaneous combustion does not occur. Some external source of heat must be present to initiate decomposition. When decomposition is once started, the reaction in itself is sufficient to produce considerable heat. This heat, known as exothermic heat, is sufficient to continue the reaction of decomposition until the nitrocellulose is entirely destroyed.

What Happens When Combustion Starts

These peculiar properties were evident in the Cleveland Clinic disaster. Although they were in a small room, six and one-quarter tons of nitrocellulose films decomposed in about twenty minutes, and within less than two feet of this mass other combustible materials, such as wood cupboards and paper records, were scarcely damaged.

This form of combustion, known as decomposition, is not complete as is the case when substances burn freely. In fact when nitrocellulose film is supplied with a plentiful amount of oxygen and allowed to burn freely, much of its hazard is removed so far as the production of poisonous gases is concerned. But when the film is packed closely together so that complete combustion cannot take place rapidly, the combustion products include carbon monoxide (CO), hydrocyanic acid gas (HCN) and other derivatives of cyanogen (CN), and those oxides of nitrogen that are highly poisonous.

Decomposition of nitrocellulose films begins at comparatively low temperatures. The temperature considered high enough to be hazardous is but slightly above the boiling point of water— 100° C. Such a temperature, if it is maintained long enough to allow heat absorption to take place until a mass of closely packed film reaches a similar temperature, will initiate violent decomposition, although this firing point may be reached only after several hours of exposure. At the same time, it must be understood that, when the heat applied is of higher temperatures, nitrocellulose film will quickly ignite and begin to decompose, even in the absence of heat absorption in any considerable quantity of film. Under such conditions, however, decomposition does not proceed as violently as when heat absorption has gone on long enough to bring larger quantities of film more nearly to the minimum firing point. The minimum firing point has been found to be approximately 130° C. in the case of duplitized radiographic nitrocellulose film.

The points presented in the foregoing paragraphs are summarized here as follows:

1. Nitrocellulose radiographic film is subject to combustion by decomposition when it is ex-

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araject exposed for varying lengths of time to relatively low temperatures from an external source of heat.

2. When decomposition is once started, the

2. When decomposition is once started, the reaction continues without assistance of the external atmosphere.

3. As decomposition proceeds copious amounts of highly poisonous gases are formed, as well as gases that are both inflammable and poisonous and gases that are relatively inert.

The inflammable qualities of nitrocellulose have long been recognized. The poisonous gas feature, however, has not been strongly emphasized. The so-called "safety film" is a product which hitherto has been considered entitled to its name largely because of the absence of the fire risk that is inherent in nitrocellulose film. This safety film is composed of cellulose acetate as a support for the emulsion layers instead of the highly inflammable gas-producing nitrocellulose. It is in all respects free from the hazards of nitrocellulose films. In effect, cellulose acetate film is no more dangerous than paper or similar materials composed largely of cellulose. The safety film has been considered free from fire hazards, without reference to poisonous gas production.

In the reduction of the poisonous gas hazards of radiographic film, the same measures will reduce fire hazards. Early in the Cleveland Clinic disaster investigation, however, it was discovered that existing regulations aimed at reducing fire risks were not sufficient to protect adequately against fatalities and physical injury from the poisonous gas hazards latent in nitrocellulose radiographic film.

The Advantages of Safety Film

From the standpoint of practical hospital administration, it is necessary that there shall be no risks involving invalids who are bedridden. The fact that the decomposition of nitrocellulose film is sufficient to decompose at the rate of six tons in about twenty minutes, with a rapid spread of fatal gases, makes the conclusion inescapable that, with a safe and satisfactory substitute available, no hospital is justified in continuing the use of the gun-cotton film. The increased expense of the safety film, approximately a fifth more than the cost of the gun-cotton film, is balanced many times by the risk of life and physical injury.

The possible deterioration of the paper films is decidedly debatable. Stability of all films depends on their care. A well known roentgenologist in Cleveland testified that he has used cellulose acetate films since their introduction five or more years ago, and he exhibited some that were

in all respects the equal of high-grade negatives on gun-cotton. The manufacturers state that experiments over a period of a good many years conclusively show that safety film negatives and the images on them are assuredly just as permanent as nitrate negatives.

Nitrocellulose Films Should Be Carefully Guarded

Many nitrocellulose negatives now on hand can be readily eliminated. Whenever possible, prints should be made at once, these prints should be filed in the records and the film disposed of safely. If this seems inadvisable, nitrocellulose films in storage should be guarded most carefully. Quantities will decide what steps are to be taken, but there are certain general rules that apply to all nitrocellulose films regardless of quantity. These rules are:

1. Nitrocellulose films should be stored where they can be readily removed in case of fire in the building.

2. They should not be stored in a place where other inflammable materials are present.

3. All persons not concerned with their storage or use should be excluded from any contact with them.

4. There should be no smoking or the use of fire in any form near the films.

5. Meticulous attention should be given to the illumination of the room with artificial light, and the use of portable electrical appliances in the neighborhood of the films should be absolutely prohibited.

6. Storage at all times should be at least two feet from any source of even moderate heat, including pipes in the storage room, within the walls or outside adjacent walls.

With regard to quantities it must be remembered that even the smallest quantity is a great This discussion refers, of course, to radiographic film in hospital administration. Photographic film, motion picture film and radiographic film as they are used outside of institutions where inmates are invalids, are helpless by reason of age or are forcibly retained require, for practical reasons, more extended consideration than is needed here. In hospitals, every guncotton film is a fire risk and must be dealt with accordingly, but for reasons already pointed out, in these institutions the only continued hazard of radiographic film should be found solely in the relatively small amounts of retained film and in the disposal of discards of the gun-cotton film negatives.

The destruction of scrapped film or film no longer needed may be accomplished readily and safely by burning it in loosely packed quantities not exceeding, say one pound at a time, in the open air away from buildings. There can be little objection to using the water route for film disposal, provided sewers are not used and only small quantities of film are considered. Of course, water used for drinking purposes should not be used for the disposal of any chemical wastes unless such disposal is made remote from points where the water is used for domestic purposes.

Water is the most efficient safeguard in preventing film decomposition and in reducing the hazards caused by decomposition. For this reason, the storage of large amounts of nitrocellulose film must include the provision of an automatic sprinkler system which will begin to operate whenever the temperature in the room rises to a degree previously decided upon as the proper time for the release of water in the neighborhood of the films. This not only prevents the beginning of decomposition but also serves in reducing the amount of poisonous gases produced. Water also absorbs some of the soluble poisonous gases. It may be stated conclusively that only when a large quantity of film is present is hydrocyanic acid gas a serious factor. This was the case in the Cleveland Clinic disaster.

All film not in use should be stored in manila envelopes, filed vertically and kept in vented metal containers. It is advisable to make use of the film safes now coming on the market which are vented to the outside air just as gas stoves and heating devices are vented by means of flues. These film safes provide for a safe disposal of poisonous gases if the vent reaches the top of the building fifty or more feet away from any opening in the building where they are stored or from adjacent occupied structures.

Choosing a Place for Storage

Under no conditions, regardless of the size of the institution, should more than a pound of film per bed be stored within buildings occupied by patients. Fifty pounds of negatives have been suggested as the maximum allowed in any such building. In storing amounts in excess of fifty pounds, other locations should be found, with the use of metal cabinets vented to the outside air, with sprinkler systems available for amounts in excess of 100 pounds and with a vault of standard construction not to exceed 750 cubic feet capacity for quantities in excess of 1,000 pounds. Roof storage in buildings occupied by bed cases is absolutely inadvisable.

In using the films, illuminators should be properly constructed in order not to heat the exposed film unduly. Prolonged exposure of film by such illuminators, as in displays, should be avoided.

X-Ray Film Storage Problem Is Not Confined to U. S. Hospitals

With the Cleveland Clinic explosion in mind, the hospital board of the Prince Alfred Hospital, Sydney, Australia, is considering carefully the question of x-ray film storage and it is certain that a scheme will shortly be adopted that will, it is hoped, prevent anything but a minimum of risk by ignition or by spontaneous combustion.

In the meantime a building has been erected on the grounds of the hospital for the storage of combustible materials used in connection with the dispensary, the operating theater and other departments. In the past there has been an accumulation of such material in the basement of one of the hospital pavilions, the *Prince Alfred Hospital Gazette* says, and the whole subject of isolating such materials so that an explosion could not affect patients in the wards has caused considerable discussion.

The building now under construction will be 14 by 12 feet as to its ground area, and the lower or floor part of the building, which will be in the nature of a well, will be enclosed by concrete walls, 2½ feet in depth.

Hospital Activities of Holland Described in Report

A report on the number and activities of hospitals in the Netherlands has been prepared by Dr. Josephus Jitta for the International Bureau of Hygiene, according to the Journal of the American Medical Association.

Five hospital beds per thousand of population are held to be sufficient for the rural districts while the cities demand eight to ten beds per thousand inhabitants. Amsterdam at present has 6.9 beds for each 1,000 inhabitants.

In general, the cities of more than 50,000 are well provided for. This is not the case in the rural districts. Because of the good transportation, however, this fact does not cause much trouble.

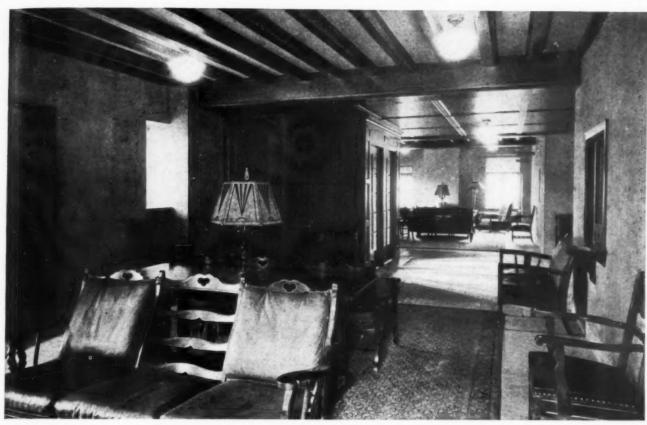
Tuberculosis sanatoriums in the Netherlands have at present the following bed equipment: 836 beds for men; 998 for women; 286 for children and 295 beds not specified, or a total of 2,415. The sanatoriums for children alone have 589 beds in addition, so that there are more than 3,000 beds available for the tuberculous in the sanatoriums.

There is a total of 20,000 beds for mental patients, or 2.8 per thousand population.

A New Philosophy in Dealing With Sickness Problems

Indicative of a new philosophy and method in dealing with problems of sickness and dependence, Governor Franklin Roosevelt of New York has started a move toward the elimination from the statute books of the state such terms as "pauper," "poorhouse," "charities," and "poor," according to Hospital Social Service.

Governor Roosevelt has recently signed the bill passed by the last session of the legislature changing the name of the state department of charities to the state board of social welfare. The ancient poor law and its related acts have likewise been erased and a public welfare law enacted in their stead.



The main lobby of the General Hospital of the University of Iowa creates an atmosphere of restful welcome.

Careful Hospital Planning Promotes Economical Administration

By ROBERT E. NEFF

Administrator, University Hospitals, University of Iowa, Iowa City

THE new General Hospital of the University of Iowa hospital group, which was completed in the late autumn and opened for patients on November 1, 1928, is ideally situated at the western edge of Iowa City. The site affords a large area of open ground, with the university eighteen-hole golf course bounding the hospital grounds immediately on the west and southwest. Proper orientation and outlook afford an abundance of sunlight, cheerfulness, pleasant surroundings and an unusual scenic view of the surrounding country. Sun parlors are arranged to permit a southern exposure. Although it is easily accessible to all kinds of traffic, the site suffers no annoyance from railroads, heavy vehicular traffic, smoke, dust of the streets or from neighboring buildings. The environment, in fact, is unexcelled.

A subway connects the General Hospital with the Children's Hospital, the Psychopathic Hospital, the West Lawn Nurses' Residence and the Medical Laboratories Building and affords a means for push trucks and pedestrian traffic as well as a passage for service lines. The subway connection makes it possible to extend to other buildings in the system, centralized services from the General Hospital, including kitchen service, storeroom service, linen room service and similar administrative services.

The building is of red brick trimmed in Indiana limestone and is accentuated as the major unit of the medical campus by a central tower. The tower of Indiana limestone rises 143 feet above the street level, and adds greatly to the architectural beauty of the building. With the aid of flood lights at night the tower is visible to the surrounding country for a radius of several miles.

The attractive and practical architectural design of the structure, its fireproof properties, and

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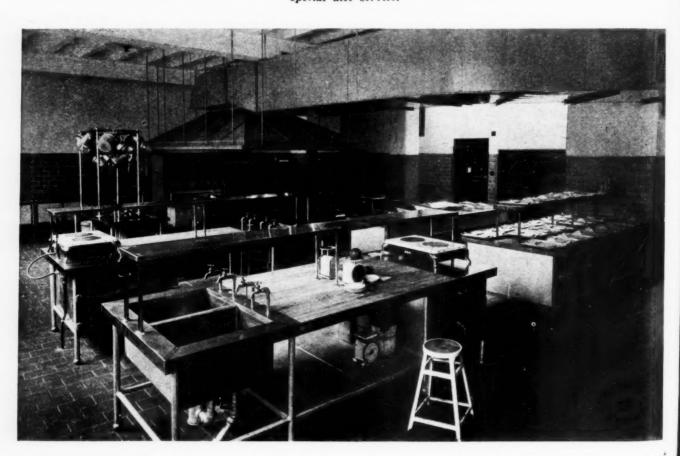
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The main kitchen with its modern labor saving devices, steam tables and built-in refrigerators is shown above. Below is shown the special diet kitchen which is equipped to prepare food for the large special diet service.



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all the modern building facilities that are embodied in it conform to the highest standards of hospital construction. Fenestration is adequate and provides large, well proportioned windows in all rooms. Rust resisting steel casement sash with 1/4-inch polished plate glass adds to the fenestration. The windows are all operated by removable cranks and are screened with double hung hinged screens mounted on the inside of the windows. The screens are placed so as not to interfere with the window operation. Dark buff canvas window shades provide a striking contrast to the red brick from the outside. Drives and walks amplify the layout of the grounds. The terrain is high, and smooth terraces slope to the street at the front of the building. Additional drives and walks, to-

systematically numbered. The initials C, E and W are affixed to each room number to indicate the section. The first digit of the number indicates the floor.

On the first floor of the west section is the isolation unit. This unit has a capacity of sixty-one beds and is designed with all facilities and features essential to the proper technique in the handling of communicable diseases. The major portion of the space is in single rooms, with several wards for diseases of similar types. Each room is provided with a toilet and lavatory. A transfer room where food trucks and supply articles may be left for the purpose of isolation is near the vestibule that connects with the main corridor of the building. An operating room, a



In the nurses' cafeteria both the graduate and the student nurses are served.

gether with shrubs and trees, are planned to emphasize the beauty of the entire medical campus. Ample parking space paved with brick and concrete curb is provided at the west and south sides of the building.

The building contains a total of 357,462 square feet or eight and a quarter acres of floor space. Its dimensions are approximately 500 by 300 feet. A cubature of 4,231,145 feet has been provided at a cost of forty-seven cents a cubic foot. This includes the general contract, plumbing, heating, wiring and hardware. There is a wall space of about 100,000 square yards. The building is arranged in three sections—the center section of seven floors and the west and east sections of four floors each. To facilitate the movements and orientation of the casual visitor, all rooms are

clothes room, a sterilizing room, a utility room, a kitchen, a laboratory and other essential services are provided and afford an operating independence from all other parts of the building.

The second and third floors of the west section contain the private and semiprivate rooms with a total of ninety-seven beds. Each room is equipped with a lavatory. Four rooms are provided with private baths. Each floor contains two utility rooms, two nurses' stations, a serving kitchen, a laboratory, a stretcher alcove, storage and linen closets and toilets. A nursery provides space for the newborn babies of private patients. Each floor has a lounge room for ambulatory patients and for guests. The room furnishings are of wood in bright colors and include a bed with Gatch frame, an adjustable bedside table, a

straight Windsor chair, an easy chair, a threepanel screen, writing desk, footstool, custumer, dresser, wastebasket and two small rugs. The floors are terrazzo. The corridor floors of this section are linoleum.

The fourth floor of the west section is assigned entirely to the obstetrical service and contains a total of forty-one beds, twenty of which are arranged in four-bed cubicles and the remainder in single and four-bed rooms. A nursery with attached bath and service room accommodates thirty-six bassinets. The serving kitchen, nursing station, utility rooms, toilets and baths are conveniently placed. An isolation nursery provides space for four additional bassinets. The dining room for ambulatory patients is attractively furnished. The two delivery rooms, one of which has a gallery for student observers, are in this section, and are in immediate connection with the patient occupancy. Labor rooms adjacent to the delivery rooms, together with physician's bedroom and toilet facilities, add to the convenience of the arrangement.

On the first and second floors of the east section are found the admission, social service, student health and out-patient departments. On the first floor, just inside of the entrance to the east section, is a spacious waiting room, 40 by 36 feet. The desk of the admitting clerk and an adjacent admitting office provide for the clerical

procedures necessary to the reception of patients. Drinking fountains, toilet rooms and seating accommodations afford comfortable facilities for waiting patients. Immediately off of the waiting room are the examining rooms of the admitting physicians. In the adjacent bath and dressing rooms, patients, upon admission, receive a bath and wearing apparel—a bathrobe, a gown, pajamas and slippers—to be worn on the wards.

The social service department with its file room, offices, consultation rooms and waiting room, is entered directly from the main waiting room of the out-patient department. The division of student health, on the first floor of this section, has its independent entrance and is amply provided with space for waiting rooms, examining rooms, conference rooms, laboratory, toilet rooms and storage rooms. The surgical out-patient service on the first floor includes space for the cast room, the departmental waiting room, the nurses' station, five examining and treatment rooms, the sterilizing room, the laboratory, the demonstration room and the chief's office. The out-patient urological service adjoins the surgical service and has been assigned four cystoscopic rooms, a sterilizing room, a demonstration room, a laboratory, a departmental waiting room and offices for the head of the department and two assistants.

The second floor of the east section, with direct



The type of utility room that is available for use in connection with each ward.

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The spacious waiting room affords comfortable facilities for patients.

and convenient communication to the first floor by stairway and elevator, continues as the outpatient department. The department of obstetrics and gynecology includes three examining rooms, a laboratory, a sterilizing room, a demonstration room and the office of the chief. The dermatology out-patient clinic, with three examining rooms, treatment rooms and the chief's office, occupies the front portion of this floor. The medical department contributes to the out-patient service in space that consists of a laboratory, a demonstration room, eight examining rooms, two offices and bath and toilet rooms. The neurology clinic, with its laboratory, its two examining rooms and the chief's office, adjoins the medical clinic. The eye clinic has adapted itself to space facilities and includes the chief's office, the waiting room, the laboratory, the treatment room, the demonstration room, two dark rooms, three refraction rooms and a perimeter room. The ear, nose and throat clinic includes a demonstration room, soundproof room, vestibular room, sterilizing room, six treatment rooms and offices for the staff. The second floor contains ample waiting room space for all clinics.

The third and fourth floors of the east section afford unusual facilities in the way of research laboratories for all clinical departments. The amphitheater, seating 242 persons, a classroom for 142 persons and five smaller classrooms that seat about forty students each, provide facilities

for student class work. The amphitheater is completely equipped with projection apparatus and has electrically controlled window shade equipment to permit daylight projection. Student locker rooms for both men and women, storage rooms and built-in refrigerators afford additional facilities for teaching requirements. The electrocardiograph station with developing facilities, the service laboratories of the hospital, the research laboratories of the department of nutrition and the staff seminar rooms are accommodated in the upper floors of the east section. The east section, it will be noted, contains no space for patients but provides chiefly for out-patient services, for student teaching and for laboratory and research facilities.

The center section of seven floors contains the major portion of the patient occupancy. There are sixteen wards that accommodate twenty patients each—four wards on the second, third, fourth and fifth floors. Adjacent to each twenty-bed ward, there are available approximately ten beds in one, two and four-bed rooms for isolation purposes. Attached to each unit are a sun parlor, a toilet and bathroom, a drug closet, a utility room, a serving pantry, a janitor's closet, a blanket warmer and two supply closets. In addition to the nurses' station in each ward, there are stations with utility rooms, stretcher alcoves and supply rooms serving advantageously the one, two and four-bed rooms adjacent to the ward

units. Intern laboratories offer facilities in close proximity to the patient areas. Two visitors' alcoves on each floor provide comfortably and conveniently for visiting friends and relatives. A serving kitchen in the center section of each floor is served by two elevators assigned exclusively to the food service.

Abundant Light and Ventilation

The ward wings receive abundant light and ventilation. The ward sun parlors have a southern exposure which adds to the therapeutic arrangement of the space. The color scheme in ward furnishings is in light gray. All beds are equipped with a two-crank adjustable Gatch frame. A Windsor chair beside each bed and a bed stand complete the major items of ward equipment. The bed stands are the enclosed type, with ventilated bedpan compartment, basin compartment and drawer. Molded rubber provides a noiseless and indestructible top. This type of stand enables the use of individual bedpan and toilet service. Treatment rooms adjoin all ward areas. Beds have been assigned to the various services as follows:

Private, single rooms	47	beds
Private, double rooms	50	beds
Ward areas		
Eye	30	beds
Ear, nose and throat	61	beds
Women's venereal	34	beds
Medicine	97	beds
Neurology	48	beds
Surgery	133	beds
Gynecology	43	beds
Genito-urinary surgery	33	beds
Men's venereal	25	beds
Isolation	61	beds
Dermatology	16	beds
Nurses' infirmary	10	beds
Maternity	41	beds
_	_	
TOTAL	729	beds
Bassinets, wards	36	
Bassinets, isolation	4	
Bassinets, private, third floor west	6	
Bassinets, private, second floor		
west	8	
	_	
TOTAL	54	

Beds are grouped by services to permit the concentration of all patients of a particular service in the same immediate area. Adjacent to its bed space, each clinical service is provided with ample intern laboratories, staff rooms and demonstration rooms.

The operating suite for general surgery and

genito-urinary surgery, occupies the entire sixth floor of the center section. Four operating rooms, measuring 16 by 19 feet and having a student observation gallery, have the advantage of the north light afforded by a window approximately 12 by 15 feet. The four operating rooms are arranged in two pairs with a scrub-up room and a sterilizing room between each set of rooms. A comfortable lounge with locker, bath and toilet facilities serves the surgical staff. A bathroom with locker facilities for intern use, and a nurses' rest room, locker room and toilet room serve these groups. The office of the chief anesthetist and two anesthetic rooms, with patients' waiting room adjacent to each, comprise the anesthetic department. A cast room, a sterilizing room, a nurses' workroom, an instrument room, a soiled linen room, supply rooms and a laboratory for surgical pathology add to the completeness of the unit.

A surgical amphitheater seating 300 persons and having an operating pit on the sixth floor level provides for large group clinics. North light by the window affords unusual natural light. Electrically controlled window shade equipment and projection apparatus provide complete facilities for daytime projection. Opaque projection, lantern slide and micro-projection from a builtin booth, from which is controlled the shade equipment, add to the completeness of this room. Sterilizing rooms, an anesthetic room, a waiting room and other essential service rooms are accessories to the operating pit. In addition to the operating area on the sixth floor, there is a separate operating space for the gynecology, the ear, nose and throat and the eye departments, each service having an operating room, with accessory service rooms which enables each to work in an independent and self-contained operating unit.

Liberal Space for X-Ray Department

The department of roentgenology occupies space on the first floor of the center and east sections and adjoins the out-patient department. Space requirements have been liberally met. They consist of a waiting room, offices, toilet and locker rooms for the staff and for patients, dark rooms, viewing rooms, a file room and nine treatment rooms equipped for all types of x-ray work. The basement storage and file rooms are directly below and are accessible by direct stairway. The film storage was planned in accordance with the requirements of the National Board of Fire Underwriters.

The administrative departments occupy the major portion of the first floor of the center sec-

tion. The main entrance below the central tower leads directly into the main lobby where the coziness of the appointments accentuates an atmosphere of restful welcome. Telephone booths and toilet rooms adjoin the lobby. Writing desks are a convenient addition. The mail room, the information service and the cashier's window are accessible from the main lobby. Near the main lobby is the telephone switchboard room which, during the night, by the opening of double windows, can be thrown into direct communication with the lobby. This arrangement permits the night operator to act as front door attendant. The central record room is in this section and is readily reached from all parts of the building.

How the Offices Are Arranged

The offices of the administrator, his secretary, the assistant to the administrator and the admission officer occupy a suite immediately adjacent to the general business office, which communicates directly with the mail and information sections. The offices of the nursing department and the school of nursing provide for the director, the secretary, two assistant directors, the educational director and two assistant educational directors. The director of housekeeping and the office of the assistant director occupy a portion of this section. The head of the department of nutrition, the secretary and six assistants occupy a suite of offices which completes the complement of the main administrative space. The offices of the nutrition department are arranged to communicate directly with the kitchen area in the service section of the building.

The basement underlies a considerable portion of the building and provides for storage space and for the housing of the mechanical departments of the hospital.

The dietary department is amply provided with kitchen and dining room space at the rear of the first floor, center section. The doctors' dining room, seating 126 persons, is colorfully furnished. Draperies bring out harmonious color effects. Specially finished table tops obviate the necessity for table cloths. A small dining room, seating sixteen persons affords facilities for small groups and adjoins the doctors' dining The nurses' cafeteria, seating 220 persons, serves the graduate nursing staff and the student nurses. The serving area of this cafeteria is arranged to serve also the doctors' dining room. A cafeteria for employees, seating 144 persons, and one for the convenience of relatives and friends of patients are operated from the same serving center. The main kitchen, across the corridor from the dining rooms and

cafeterias, is equipped with modern, labor saving devices. Gas ranges, steam jacketed kettles, meat roasters, vegetable cookers and steam tables make up the major portion of the equipment. Adjoining the main kitchen are the pastry kitchen, the vegetable preparation room, the meat cutting room and storage space for food and tray trucks. Built-in refrigerators arranged in sections for the various classes of foods provide unusual and commodious refrigeration facilities. The kitchen area is designed and equipped to serve also the requirements of the Children's Hospital. Food is conveyed by subway on electrically heated food trucks. A central dishwashing kitchen with two complete sterilizing and washing outfits adjoins the main kitchen. food elevators, one for up and one for down traffic, give exclusive elevator service between the kitchen section and the various wards. special diet kitchen with floor space measuring 46 by 38 feet is equipped to handle the large special diet service. Red quarry tile floors and glazed yellow brick wainscot, to the height of eight feet, enhance the sanitary features of the kitchen section. On each ward floor, an auxiliary kitchen that is entered directly from the elevator service is an aid in the distribution of the food service. Coffee only is prepared here. All other foods come directly from the main kitchen, from which point also all nourishments are prepared and dispensed. This plan does away with the keeping of food supplies in ward kitchens.

Food Served Directly to the Patients

Food is served to patients by a direct method. Electrically heated food trucks of the insulated type carry food in bulk containers from the kitchens directly into the wards. Food trucks are followed by tray trucks containing twenty trays, each completely set up and ready for service. Food is served from the truck to the tray and delivered promptly to the patient. Soiled trays are collected and placed in the tray cart which, when filled, is moved to the central dishwashing kitchen on the first floor. There they are scraped, washed and stored for the next meal. This plan ensures hot, palatable food and eliminates entirely the handling of utensils and dishes in the nursing areas. Service direct from the main kitchen, in the serving of meals and of all nourishments between meals, is convincing in its contribution to low food costs. Monel metal has been used extensively throughout the kitchens, in cabinets, tables and other equipment calling for sanitation and durability.

The telephone system provides approximately 150 stations in the building with outside connec-

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tions through two switchboards. More than 12,-000 feet of telephone conduit was placed for use in connection with the cabling and wiring of the building, and about 35,000 feet of inside wire was required to connect to the individual stations. Seventy-two private rooms are served as jackended lines for portable sets. Four pay stations are distributed at various points about the building.

Unusual elevator facilities make possible the swift movement of vertical traffic at all times. Eight elevators provide this service. Two elevators are devoted to patient traffic exclusively, three to general passenger traffic, two to food service and one to the transportation of freight. All elevators are of the improved automatic type with a micro-leveling device. Two of the passenger elevators in the center section of the building are equipped with a collective control which provides a mechanism of almost human possibilities in the control and service of these elevators.

A central linen room in the service section of the building and near the receiving entrance is the center of the linen distributing scheme. Linens are handled on the exchange plan. Soiled linen is collected daily from the various departments and is carefully listed and checked in by each department. The list of soiled linen becomes the requisition for the fresh linen to be sent in exchange. All soiled linen is sent directly to the shipping room where it is sacked and sent to the central laundry plant operated by the university. Fresh linens from the laundry are delivered to the linen room, from which point requisitions are filled corresponding in their exactness to the list of soiled linens last collected from the department concerned. A sewing room adjoins the linen room.

Nurses Have Their Own Infirmary

A nurses' infirmary of ten beds has been set aside for the exclusive care of sick nurses. Utility, toilet and other essential service rooms make this section an independent, self-contained unit which affords a place for the care of nurses apart from other patient groups.

The interns' residence suite is located on the fourth and fifth floors of the center section. Quarters for fifty-one interns are provided. Each room has abundant light and ventilation and ample toilet and bath facilities. There is also a homelike lounge room in this section.

The physical therapy department is on the seventh floor of the center section. The floors are white hexagon tile. Marble wainscot, eight feet high, runs throughout this department. Duplicate equipment in two sections of the de-

partment eliminates any conflict in the simultaneous treatment of male and female patients. Various types of hydrotherapeutic equipment include leg and arm baths, bath cabinets, a needle shower with control table, a Sitz bath, and a tub for continuous bathing. A special section for electrotherapeutics is a part of this department. Waiting room, massage rooms and dressing rooms are a part of the service. Ample space is available for enlarging the physical therapy service in its various branches.

Tube System Facilitates Record Service

A pneumatic tube system has been installed with the central station in the record room. A connection with the Children's Hospital makes possible a central record service as well as a central x-ray department, both of which serve the General Hospital and the Children's Hospital. The system includes thirteen stations and, in addition, one station in the record room at the Children's Hospital. The stations are placed at strategic points about the building. The system provides swift transportation of patients' records between the various departments and the record room, as well as a prompt dispatch of x-ray films from the x-ray department and of special prescriptions from the pharmacy.

A signal call system facilitates rapid communication with the physicians and hospital personnel. The system is the silent, flash light type, controlled and operated by the telephone operators in the telephone switchboard room. The system consists of three basic devices—an operator's keyboard, a relay control panel and sixtysix lamp annunciators. The annunciators are installed in the corridors, classrooms and other public areas and are equitably distributed about the building. Illuminated numbers corresponding to the assigned number of the person called flash intermittently in three-digit numbers. The duration of the signals is .82 seconds, and the time elapsing between flashes is .54 seconds.

The heating and ventilation systems are thoroughly modern. Automatic heat control has been provided in lecture rooms, laboratories, waiting rooms and similar places. Individual heat control affords an independent means of meeting the individual desires of patients in private rooms. Radiation is supplemented by a forced air system of the latest design. Washed air is supplied to the operating rooms from an individual unit. In addition to providing these areas with purified air, this unit contributes to the relative humidity of the atmosphere to the extent of reducing the hazards and risks resulting from the use of inhalation anesthetics.

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Cost of Hospital Service as Viewed by a Hospital Executive*

By G. W. OLSON

Superintendent, California Lutheran Hospital, Los Angeles

IN RECENT years there has been repeated agitation by the press against the alleged excessive cost of medical service. Much of this has been directed against hospitals. Many unjust accusations have been hurled at the modern hospital.

In an address made before the American Col-

lege of Surgeons in Chicago, Dr. William J. Mayo stated that hospitals were using high pressure sales methods and deliberately saddling high priced hosaccommodations upon those who could not afford them. I do not know just what basis of facts Doctor Mayo may have for his statement, but, as far as I know, it surely has no application in Pacific Coast hospitals. Instead of urging the pa-

tient to take accommodations that he cannot afford, we train our admitting officers and clerks to ascertain carefully whether he can pay for the accommodations reserved, the reservation usually having been made through the doctor's office. If there is any doubt about the patient's being able to pay, he is urged to take a lower priced room or a ward bed. In many cases the mere suggestion that the patient should consider the cost and try to economize is met with the haughty remark that the hospital need not concern itself and that if he wants to engage the highest priced accommodations in the hospital, he feels at liberty to do Later, it is often found that such persons have a real financial problem, and it takes much time and effort on the part of the hospital's social worker to help them find friends or relatives from which they can get the necessary financial aid to help them pay for their hospital care.

The trouble is not with the hospital, but with the extravagant ideas of the modern public. Because every little home now has a bathroom or two, the people who live in these homes feel that they must have the same facilities in connection with their room in the hospital. They want plenty of room to receive visitors and flowers.

Often the hospital is called upon to extend credit over a long period and in large amounts to patients with such ideas who are in moderate circumstances. To urge them to be more economical causes them to feel highly offended.

Hospital costs are high, but when compared with other expenses such as those of hotels, transportation and wearing apparel, they have not advanced

hotels, transportation and wearing apparel, they have not advanced in undue proportion since the prewar period. I have just completed twenty years in hospital work. Twenty years ago a private room in the hospital cost \$5 a day. The room was plainly furnished and bare of comforts such as people demand to-day. In those days graduate nurses received \$50 to \$60 a month, floor maids and kitchen maids, \$12 to \$15 a month and competent janitors working twelve hours a day, \$25 to \$30 a month. Butter was 25 cents a pound and was served more sparingly than to-day; eggs were 15

To-day, nurses receive \$100 a month; they work shorter hours and therefore the hospital requires more nurses. Maids are paid \$50 to \$60 a month and work only eight hours, whereas under

cents a dozen and were not served every day; the

best grades of meat in wholesale quantities rarely

cost over 10 or 12 cents a pound. In furnishing

the hospital, a ward bed could be bought for \$5

and a mattress for \$3.50; pillows were 50 cents

A Financial Problem

THE criticism has been made that hospitals have forced high priced accommodations on patients who could not afford them. Until the patient with moderate means is convinced that he should not demand hospital care that he cannot afford and until the residents of a community are willing to make gifts to their hospital to wipe out capital debts and to provide adequate endowment, the cost of hospital service cannot be appreciably lowered.

⁶Discussion read at the annual meeting of the Western Hospital Association, Portland, Ore., Oct. 24-25, 1929.

the old rules they worked ten to twelve hours; consequently more maids are needed. Janitors are paid \$60 to \$75 a month and also work shorter hours, making more men necessary. Everyone knows how much higher priced food supplies are, and the hospital, like any other consumer, must pay the current price. Hospital beds have been redesigned and perfected until they now cost from \$40 up to \$200 for a bed suitable for the care of a fracture case. Ward

special rate much below the regular rate for the accommodations she was receiving, yet she had the boldness to say that unless she were given the best mattress she would certainly let the world know "what kind of a hospital this was." This woman is representative of the type of economy that rules the minds of some people to-day. The great majority want the best whether they can afford it or not. If they know that there is anything better in the hospital than they are being

	Patient	Per			
	Day Cost				
Administration (executive and clerical salaries, office supplies and expense, postage, tele-	Day Cost	Cen			
graph, telephone, insurance, legal publicity)	\$0.810	12.0			
Housekeeping (maids, porters, cleaning supplies, linens, uniforms)	0.400	6.0			
Touches (action and line and l	0.180	2.7			
Laundry (salaries, supplies, repairs)					
and electrical supplies)	0.373	5.6			
Maintenance and repairs (salaries of carpenters and painters, materials)		2.0			
plies and expenses)	1.460	21.7			
supplies of record department)	0.150	2.2			
Surgical supplies (gauze, cotton, all bandage materials, instruments)	0.203	3.0			
Dietary and stores Patient Day Cost					
Food supplies \$1.065					
Dishes, utensils and miscellaneous 0.065					
Salaries - 0.430					
Total cost, dietary department	1.560	23.3			
Taxes		3.5			
Bad debts reserve		2.0			
		3.2			
Laboratory	0.210				
X-ray department and electrocardiograph		4.3			
Therapy departments		1.5			
Pharmacy	0.460	7.0			
Total	\$6.70	100.0			
regular force of workers	\$5.64	84			
partments, pharmacy)	1.06	16			
	\$6.70	100			
INCOME OF HOSPITAL PER DAY PER PATIENT IN 1928					
	Patient	Per			
Da	y Income	Cent			
Amount derived from the general institutional services, per patient day	\$7.18	80			
charges for services or goods supplied		20			
	\$9.00	100			
Net earnings on institutional services per day per patient		22			
Net earnings on other services per day per patient	0.76	41			

patients paying less than the cost of mere board and nursing demand those \$200 beds, and the doctor insists that they must have them. Patients now demand the best type of mattresses, which cost \$25 or more each. The California Lutheran Hospital, Los Angeles, has a large number of these mattresses, but is not able to afford this type or the high priced modern bed in its wards.

Recently a woman patient in one of the wards insisted that she be given an inner spring mattress, which she said she knew the hospital had in its private rooms. She had been admitted at a

supplied with, they insist that it be given them. When the fact of cost is mentioned they become incensed and accuse the hospital of being mercenary and inhuman. This is the basis of much of the complaint we hear against hospital costs to-day.

Returning to the comparison of costs to-day and those of twenty years ago, we find that the hospital room that then cost \$5 a day can now be had for \$7.50 or \$8.50, but it is not the same room in any respect. The type of hospital room that was offered at \$5 a day in 1909 does not exist to-

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day. First, the room of twenty years ago was usually in a nonfireproof building; second, the equipment did not cost one-tenth as much as it would to-day and would be regarded as utterly obsolete; third, the modern hospital room is supplemented and served by utilities that have doubled the capital investment per room or bed. This change has come about not through the extravagance of hospital administrators, but in response to the insistent demand of the public. During the same period, all of the technical equipment of the hospital has been completely changed several times, necessitating the frequent renewal of x-ray facilities and other expensive accessories necessary for the proper performance of the functions of the hospital, many of which did not exist twenty years ago.

Hospital Stay Greatly Shortened

Because of all these developments and improvements, including the more efficient training of nurses and the fact that more of them are on actual duty, the average length of stay of patients in the hospital has been reduced from twenty-one days in 1909 to eleven days in 1929. The old time hospital service at \$5 a day for twenty-one days would cost \$105; the new type at \$8.50 a day for eleven days would cost \$93.50. Where does the increased cost come in? Only in the price list, not in the total outlay for the service received. No account is taken here of the value of the time saved to the patient.

It is safe to assert that all hospitals would like to be able to reduce their rates. It cannot be done, however, unless money is donated to pay off their capital indebtedness. Then all of the money now collected from the sick to pay interest and to pay off capital debts could be left in the pockets of the patients. In the California Lutheran Hospital this would amount to about \$2 a day. In California the state should not tax nonprofitable hospitals and other charitable institutions, which no other state does. This would reduce the cost to every hospital patient in California 25 cents or more a day.

The schools of nursing conducted by hospitals should be endowed. This is just as worthy an educational activity as any college for general education. Its graduates are just as essential to the welfare of the community as are those of any other schools. If these schools were fully endowed, another dollar a day could be deducted from the hospital bill. The x-ray and laboratory departments of the hospital should be endowed so that no charge would be necessary for the services of these indispensable diagnostic aids. There would then remain only the wages of the

workers, the cost of the food supplies, the medical and surgical supplies, necessary repairs and maintenance, the utility services, such as water, fuel, power and light, and the cost of insurance for protection against every hazard to which the hospital is exposed (this item alone is fifteen hundred dollars a month or more for a 300-bed hospital). Even with only these items remaining to be paid out of the operating income, the cost to the sick would be far beyond the ability of many to pay. A gift of \$100,000 as an endowment for a hospital would be regarded as a very big thing which should yield much free service for the sick. As a matter of fact, the income from such an endowment well invested would do little more than pay the telephone bills of the average hospital for one year. This illustrates how stupendous is the endowment required appreciably to reduce the cost to the sick.

It might be of interest in this discussion to give a brief analysis of the costs in a modern general hospital of 300 beds, economically built and operated in strict accord with a policy that provides for good service without extravagance. This hospital with a daily average patient population of 255, or 85 per cent of its capacity, had an average patient day cost of \$6.70 in 1928. The distribution of this cost is shown in the accompanying table.

In the expense account given in the table there is no mention of depreciation or interest on a property valuation of \$2,500,000 with a debt of over \$1,750,000, at 7 per cent. These two items are as follows:

	Per Patient Day		
Depreciation	\$68,282.04	\$0.734	
Interest	140,352.65	1.506	

Total of these charges....\$208,634.69 \$2.240

Of our profit of \$2.30 a day per patient, there now remains 6 cents a day per patient. This is all the reduction the hospital could possibly have made in its charges without creating a deficit and defaulting on its financial obligations.

The Hospital's Hands Are Tied

In the figures quoted, where are the possibilities of reducing the cost to the sick? The hospital cannot dispense with any of the services offered. Wages cannot be cut and the number of persons employed cannot be reduced; on the contrary, nurses are now pleading for a shorter work day which, if granted, means more expense on this service. The only hope of any reduction lies in paying off the debt and stopping interest charges and in dropping sound bookkeeping methods and eliminating depreciation, leaving a worn-

out and depleted hospital plant for the next generation to reconstruct. In this way only, the hospital could reduce the average cost to its patients \$2.30 a day, bringing it down from \$9.00 to \$6.70.

The hospital now earns somewhat less than this amount in its wards, which constitute one-third of its capacity. In its semiprivate rooms, constituting another third of its capacity, it earns an average of about \$7.00 a patient day, while from the private rooms, also making up about one-third of the bed capacity, is derived the profit that enables the hospital to meet its obligations. The patient of moderate means is being subsidized now in the wards of all private general hospitals. The middle class patient, if he uses semiprivate accommodations, is paying about cost. The patient of means who chooses private room service at the present rates pays a moderate profit which enables the hospital to function in a reasonably businesslike way. What is wrong with this system? Until the people in any community are willing to make gifts to their hospital to wipe out its capital debts and provide it with endowments to cover eventual deficits, they will have to continue to pay the present hospital rates.

There is no royal road to reduction of hospital costs, no magic method whereby they can be lowered. If they are not paid in the form of hospital bills, they must be paid through voluntary gifts for the eradication of debts, for permanent endowments and for building funds for future expansion and development.

The Social Worker's Responsibility to the Mental Patient

"The helping hands of the state and county mental hospitals in New Jersey are extended to their patients even after they have restored them to health and the patients have returned to their homes," William J. Ellis, commissioner, New Jersey State Department of Institutions and Agencies, Trenton, writes in the *United States Daily*. "Realizing that the person who has just recovered from a mental ailment is not prepared to face his home community alone, the hospitals provide extra-institutional care through social service agents."

He continues: "When patients of the New Jersey mental hospitals are returned to their home communities, the social workers cooperate with the families and friends of these patients to get them adjusted socially and economically. It is recognized that if a recurrence of the disease is to be prevented, the conditions which caused the original mental difficulty must not be encountered a second time. Aggravating situations in the environment must be removed and favorable ones substituted. Families must be taught to treat the returned patient sympathetically and to be as understanding as possible.

"The work of the social service agents begins with the patient's admittance to the hospital and ends when his recovery is complete. Before a case is discussed by the medical staff for discharge from the hospital, the social

worker has assembled the history of the patient from talks with his family, employers and physicians.

"Upon the social worker rests the responsibility of helping to discover and correct problems that are interfering with the patient's recovery. The social worker must also investigate the home conditions which the patient will encounter on his discharge and determine the advisability of parole. During the parole of the patient the field agent keeps close check on his condition and makes detailed reports to the hospital authorities.

"Social service work is well developed in New Jersey and county mental hospitals and has become an integral part of the curative efforts of these institutions. In the last twelve months at the Greystone Park State Hospital the average number of patients on parole requiring the services of the social workers was over 350. The social service visits made in the course of the year in the welfare of the hospital patients totaled more than 4,000.

"At the present time there are at the Trenton State Hospital a considerable number of patients listed as recovered and the full report of their readjustment to the community is one of the important contributions to the hospital work made by the social service agents. At the Essex County Hospital for the Insane there was a total of 622 different patients who were on parole for some period of the time during the past year and required numerous visits by the social service workers.

"Medical and material aid and employment were secured for these patients and their families in many cases. Certain commitments were investigated and the social service division was instrumental in securing trial visits of many patients who were homeless and whose relatives were reluctant to receive them. Efforts were made to locate friends and families of patients sent to the hospital with a record of being friendless.

"The primary object of the social service work of mental hospitals is to assist the patient to make his adjustment in the home and in the community and beyond that to see that conditions do not arise which might be the cause of a new breakdown and necessitate the patient's return to the hospital. The social service work carried on by the New Jersey mental hospitals thus becomes of great benefit to the patient and his family."

Comparing Hospital Rates With Soaring Costs in Other Fields

"A study of the rates in 150 representative American hospitals shows an increase of 119 per cent in the East, 108 per cent in the Middle West and 61 per cent in the Far West—a nationwide average of 96 per cent for the period from 1914 to 1927," Dr. Cleon C. Mason writes in the North American Review. "During this time hotel rates, the only comparable business, increased 131 per cent. According to Department of Labor statistics, the following increases took place: kitchen help, 432 per cent; maids, 125 per cent; pharmacists, 500 per cent; interns, 525 per cent; laundrymen, 400 per cent; chefs, 225 per cent.

"The same period saw these costs soar: raw foods, 58.5 per cent; fuel, 80 per cent; dishes, 100 per cent; blankets, 63 per cent; absorbent cotton, 71 per cent; instruments, 75 per cent.

"All these are necessary in a hospital. The list is incomplete but it is representative of what has happened not only in hospitals but in every other business in America."

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A Modern Laundry Plant That Serves a 700-Bed Hospital

By HARRY L. SPOONER Detroit, Mich.

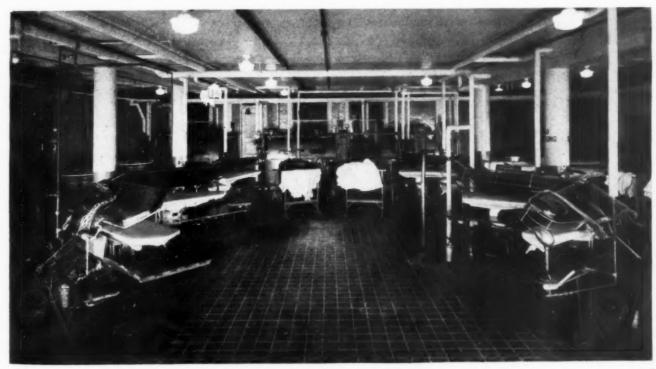
HEN Harper Hospital, Detroit, began planning its new 450-bed addition, which was opened in May, 1928, it was apparent that provisions would have to be made for a laundry plant to provide for the requirements of the additional bed capacity as well as the needs of the nurses, interns and other employees.

The main building of Harper Hospital consists of three units. A large nurses' home stands on the same lot and the interns' quarters are across the street. The original unit of the main building was opened in 1884. It had accommodations for 250 patients. The second unit, the J. L. Hudson memorial unit, was opened in 1914 with a bed capacity of 200. The new addition, opened in 1928, has facilities for 450 patients. When this addition was made available, most of the original unit was given over to service purposes, accommodations for fifty patients being reserved for orthopedic and industrial surgery. The capacity of the hospital at the present time is 700.

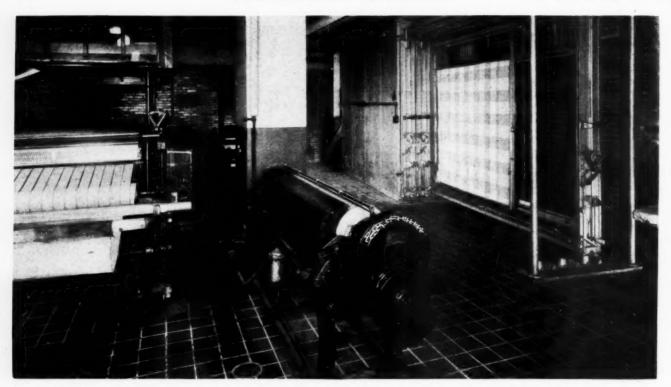
Prior to the building of the new addition, a laundry plant had been operated in a small build-

ing at the rear of the hospital. This building, however, had to be razed to make room for the building operations. The laundry had been in operation for twenty-nine years and most of the equipment was obsolete. It was determined, therefore, to include a modern laundry plant in the building specifications.

The location of the laundry was given considerable thought. It had to be in the addition since there was no suitable place for it in the original building. It was finally decided to place it in the basement, although the management realized that this was not altogether an ideal location. If it could have been placed on the ground floor or on the top floor, the lighting, temperature and humidity conditions would have been better. Artificial lighting, no matter how excellent, cannot show up the desired whiteness of the laundered articles so well as natural daylight. The abnormal temperature and humidity in a basement and the artificial light are not, as a rule, conducive to the comfort of the employees. On the other hand, having the laundry on the top



The pressing department of the laundry at Harper Hospital, Detroit.



Blankets are laundered in a special washer and are dried in a room devoted especially to this purpose.

floor would have meant considerable loss in power and in the temperature of the water used, which, of course, would have required more fuel to make good the shortage. The laundered materials would have had to be transported both up and down by elevator, which would have meant much additional work. The elevator, too, would have had to pass through the part of the building devoted to patients, naturally causing confusion.

15,000 Pieces Laundered Daily

The laundry stands next to the power plant, with only a wall between. A forced ventilation system is in use. A canopy top over the flatwork ironers automatically removes a large portion of the heat and moisture from the rolls and delivers it into the ventilators to be carried out of the building. All steam pipes are covered with asbestos to keep the heat in the pipes rather than to allow it to be radiated throughout the room. No patients' rooms are over the laundry. Instead the x-ray department occupies this space. The fact that the floors of the building are soundproof, heatproof and smellproof makes it impossible for any untoward conditions in the laundry plant to affect any part of the building and especially that part devoted to patients.

Although it was impossible to attain perfection in the matter of locating the laundry plant, no such limitation was imposed on the quality of the equipment and on its layout. The laundry room with its 5,000 square feet of floor space provides

ample room for the various operations. It has a tile floor which is easily cleaned. On one side are the washing machines, six in all. Four of these are 42 by 84 inches, one is 42 by 64 inches and one is a pony washer. All except the last are the latest design of monel metal automatic unloading machines. An overhead conveyor takes the washed goods to two self-dumping extractors, at right angles to the washers. After extracting, the conveyors take the goods directly to shaking tables in the center of the room with the flatwork ironers on one side and the drying tumblers and presses on the other. The goods thus make a complete circuit from washers to the finishing operations. The washing equipment stands over deep gutters which carry away the waste water so efficiently that no unsightly pools deface the floor. It is as dry under and around the washers as in any other part of the plant.

Two flatwork ironers are required. These are eight-roll, 120-inch, chest type, stream line machines, provided with canopy tops. Two drying tumblers, a shirt unit and eight 51-inch motor-driven presses are required for the garments laundered. Handkerchiefs are ironed on a regular single roll handkerchief ironer. Six hand ironers give the finishing touches to garments from the presses. A starch cooker is used to prepare the starch required. The starch work alone makes up a considerable item. There are 260 student nurses besides 100 graduate nurses on hall duty, each of whom uses seven aprons,

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seven bibs, seven pairs of cuffs and five collars weekly. Sixty interns use five suits of coats and trousers a week. Each probationary nurse requires two checked uniforms a week. Five white uniforms a week must be laundered for each of the twenty-six supervisors and six uniforms a week for each of the ten nurses in the diet kitchens. The volume of flatwork is also tremendous. The average number of bed patients per year is 17,500, while 50,000 persons visit the clinic annually. The linens necessary for these, together with those required for the dining rooms and other service departments, make up a staggering volume.

The equipment was installed at an approximate price of \$49,000. An average of thirty-five persons is employed. These work six days a week and eight hours a day. The help turnover is small. Laundry work begins coming into the plant at 8 a.m. and by 1:30 p.m. it is usually all in. By 4:30 p.m. when work ceases for the day, practically all work is out, except a small amount left over for the next morning to keep the help busy until the day's work begins to come in again. The nurses' and interns' uniforms are washed on Tuesday and finished on Friday. Flatwork is washed every operating day. The operators are required to oil and keep clean the equipment in their charge. Repairs are done by the general engineers and electricians of the hospital. There is one washman and one extractor man, with a handy man who does the janitor work, keeps the plant clean and helps run the washers and extractors when it is necessary.

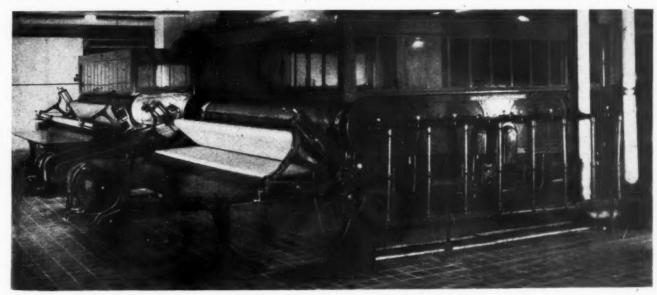
An average of 15,000 pieces of work passes through the plant daily. The following pieces are included: bed linens from patients' beds; bed linens from nurses' home and interns' quarters;

linens from operating rooms, x-ray rooms; linens from dining rooms; nurses' wearing apparel, consisting of caps, bibs, uniforms and personal laundry; interns' uniforms of white coats, pants, shirts, collars, cuffs and personal laundry; orderlies' uniforms and personal laundry; linens from kitchens and uniforms and aprons of kitchen help; all curtains used in the building; all blankets used on patients', nurses', interns', and other employees' beds. Blankets are washed in a special blanket washer and dried in a blanket dry room. Curtains are washed by themselves and are passed through the flatwork ironer. Linens from the surgical department are given special treatment, receiving an extra "break" or two and as many rinsings as are necessary.

How the Linens Are Collected

The hospital is divided into divisions, twenty-six in all, each of which has a supervisor who has charge of the nurses in her division. The nurses, when they change the beds, place the soiled linens in chutes leading to the basement. There are five of these chutes in different parts of the building, one of which comes directly to the laundry. Gravity is thus made to help transport the soiled linens. Two men collect the laundry from these chutes in portable baskets, which are wheeled through the corridors to the laundry. The laundry from each division is stamped with the number of the division to which it belongs.

The dining room linens and the various uniforms are also placed in the chutes and reach the laundry in the same way. The kitchen is on the same floor with the laundry and the kitchen work is gathered and placed directly in the wheeled baskets. Linens from the nurses' home are brought in the wheeled baskets through a tunnel



The enormous flatwork ironers are covered with canopy tops.

from the home to the main building. Those from the interns' quarters across the street are taken in an automobile to the laundry. The laundry from the surgical department is placed in bags before it is sent down the chutes. All other soiled linens are in bulk.

Arriving at the laundry, the goods are immediately washed. Since nearly all the goods are white, but little classification is necessary. What colored goods there are are placed in nets for washing. The same is true of small white articles, as bibs, collars and handkerchiefs. All the larger pieces are bulk washed. Little sorting is required as the pieces from each division all come at one time and all make up full wash loads.

When the laundry operation is completed, the main hospital linens are wheeled to the linen room which is a nice light room, 23 by 38 feet, directly across the corridor from the This room has plenty of large tables where the articles are sorted as to kind and as to departments. After sorting, they are placed on shelves and in bins, an abundance of which are provided for this purpose. Besides the flatwork, the orderlies' coats are also stored in this room. As the sorting goes on, articles that need repairing are sent to the sewing room on the fifth floor. They are then returned to the linen room. Six women are employed in the sewing room. When they are not making repairs, they are kept busy making new uniforms for the nurses.

Requisition System in Force

Nothing is allowed to leave the linen room except upon requisition. Each morning each supervisor sends her requisition properly signed to the linen room and an employee from this room delivers the order to the floor. The supervisor issues the linen required to the nurses, and any surplus is kept in a small supply room on the floor. The orderlies do not have their personal coats, but all sizes are kept on hand and the requisition may secure the desired sizes. nurses' linen supply room, to which the laundered articles are taken directly from the laundry, is on the first floor. The procedure here is much the same as in the general linen room except that the clothing worn by the nurses is personal. It comes into the laundry on a ticket, the same as in a commercial laundry, and is delivered with the ticket to the proper person. The linen room for interns is in their own building. Their linen, also personal, is handled in much the same way as that of the nurses.

The requisition system is also applied to laundry supplies. A purchasing agent attends to

all the buying for the hospital. All goods are stored in the commissary next to the laundry, which makes the transfer of supplies convenient. The laundry manager sends a requisition to the commissary for whatever is needed and is thus relieved of all trouble in connection with buying and storing supplies.

Advantages of the Institutional Laundry

When the new addition was in course of construction, it was necessary to send the laundry work to a commercial plant. This commercial plant, one of the best in the city, gave the hospital good service. But the experience only emphasized the desirability of having a laundry plant in the building. In the first place the work can be done more cheaply, since there are no pick-up and delivery costs and no profits to be paid. In the second place, when the work is done by a commercial laundry, a large reserve stock of linens has to be carried to guard against any emergencies resulting in the failure of the commercial plant to get the work out on time. There is also the question of service. Due to the extra time required to pick up and deliver the work and the inability to crowd other work out, the commercial laundry, operating at its best, cannot give a service comparable to the self-contained plant. In emergency cases, the home operated plant can do the work while the commercial plant laundry collector is on his way.

The plant under the direct supervision of the hospital management has the advantage of controlling the processes of laundry practice. The management knows exactly what supplies and what methods are being used. By being able to control these methods, he can standardize the practice in such a way that it results in longer life to the fabrics laundered.

Effective Garbage Disposal in a Hospital for the Tuberculous

The National Sanitarium at Weston, Ontario, has found an effective way of disposing of its garbage and at the same time of enchancing its annual income, according to an article in the *Trained Nurse and Hospital Review*. It has established a piggery and a poultry plant of its own which effectively dispose of all garbage. Establishing the plants was a matter of stern necessity, since the hospital could find no person who would remove the garbage because it came from an institution for the tuberculous

All garbage of course is sterilized by steam from the central heating plant before it is used for feed. Fifty pigs are kept in the piggery, and supply the hospital of 392 beds with fresh pork. The poultry house shelters 500 Leghorns. In 1927, the hens laid 41,088 eggs—one third of the hospital's egg needs for the year.

How to Maintain Efficient Case Records*

By MARJORIE H. BOULTON Record Librarian, Jewish Hospital, St. Louis

THE examination of the record department of any hospital reveals interest in the progress of scientific medicine or discloses a lack of it. Perhaps there is no better evidence of the quality of the hospital's service than that disclosed by the record room which it maintains.

The word record, according to the best authorities, means "authentic evidence." Therefore the essentials of a hospital record are that it should be authentic and reliable in every detail.

Hospital records should be accessible in order that they may be quickly obtained if they are needed and they should be simple enough to permit their correct interpretation in later years.

Adequate Staff and Equipment Necessary

How, then, can this authentic evidence be obtained and properly maintained? Efficient service in the record room, as in any other hospital department, necessitates a properly qualified staff and adequate equipment. The record room should be well lighted, comfortably furnished and sufficiently large to provide a quiet place where members of the medical staff can study the records without being interrupted or disturbed. It should be safeguarded against possible loss, as hospital records are not easily replaced. This is no implication against anyone's honesty, but is an admission of human frailty. A misplaced record may mean irreparable loss to the patient and may be a source of embarrassment to the hospital. The information contained in hospital records should be kept inviolate and should be available only to those for whom it is intended.

The records should be complete and always compiled with the viewpoint of their future contribution to research, for as the years pass the record department should become a valuable storehouse of vital statistics.

The method with which I am most familiar is that which has been established in the Jewish Hospital, St. Louis. It is as follows:

The first step in the making of a hospital rec-

ord, although simple, is of extreme importance—that of securing the full name of the patient, his correct address, the hour and date of his admission, his age, marital state, nationality and occupation, the name and address of his nearest relative, and the name of the attending physician, all of which are essential for identification. These important data are secured by the admitting officer who is held responsible for the record of the twenty-four hour summary of patients admitted and discharged from the hospital. A duplicate of this information is transferred to a face sheet for the initial chart and accompanies the patient to the ward or division.

If the patient has been previously admitted to the hospital, the admitting officer notifies the record clerk and the patient's name card is removed from the permanent file and placed in the active file of patients in the hospital. As we use a loose-leaf system, his previous record is removed from the binder and is taken to the division, becoming a part of his new record. If the patient has passed through the out-patient clinic, that department delivers its record to the ward and it becomes a part of the record.

In order permanently to link the records of the hospital and the out-patient clinic, the complete record is delivered to the out-patient department upon the discharge of any free patient, where it is abstracted in the out-patient clinic records. The hospital record is then returned to the record room.

How Records Are Kept

However, the complete hospital record is always available and, since the out-patient clinic is run on the appointment system, a list of patients scheduled to return daily is checked by a clerk who obtains the hospital records from the record room and returns them by 4 p.m. daily. The clerk who obtains such records is held responsible for their return to the record librarian, who requires her signature for all charts. (The two libraries are separated, as the clinic is in a separate building adjacent to the hospital.)

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^eRead before the Hospital Standardization Conference of the American College of Surgeons, Chicago, Oct. 14-17, 1929.

Immediately upon the admission of a patient, the resident is notified by the admitting office. After a preliminary examination he assigns the patient to the service to which he belongs, calls the attending physician, receives his orders and transfers them to the intern in charge of the service. The intern records an admission note, stating the present condition of the patient, and in the doctor's order book writes instructions to be carried out by the nurses.

A complete history and a physical and routine laboratory examination must be recorded within twenty-four hours after the patient's admission to the hospital. Postoperative notes must be written daily on all surgical cases until the patient is considered convalescent and out of danger; then progress notes are written less frequently. The operative and anesthetic notes are placed on the record within twenty-four hours after operation. The attending physician makes notes of his findings. No history is filed without a final note from the physician and his diagnosis.

A record of all laboratory findings, x-ray examinations, basal metabolism tests and electrocardiograms is made in triplicate form, one copy being retained in the department for future reference, a second copy placed with the chart on the division, while a third is sent to the attending physician for his personal files. This avoids the possible loss of such records.

The twenty-four hour summary of patients admitted to the hospital is sent daily to the electrocardiograph, basal metabolism and x-ray departments, and is checked carefully to determine whether the patient has been admitted previously as an ambulatory case. This often avoids the repetition of laboratory work and reduces the patient's hospital bill.

Data Are Checked Carefully

Upon the discharge of the patient from the hospital, a brief résumé is made by the intern, stating the patient's condition and his diagnosis.

Charts on the division are inspected three times weekly by the record librarian, who makes a notation of any missing data and calls the resident's attention to such delinquencies.

After the patient is discharged and the chart is sent to the record room, it is inspected for any possible missing data. Incomplete charts are kept separate and a notation of the doctor who is responsible placed on the back of the patient's name card. The card is then filed alphabetically in the incomplete name card file and the chart filed under the name of the physician responsible for finishing it. This method ensures the availability of the record at all times.

Staff physicians who make daily visits to the hospital are notified of their delinquencies by means of the bulletin board. However, the record librarian of the Jewish Hospital has a decided advantage over many record librarians, in that the staff room adjoins the record room, which makes it possible for daily contact with the physicians.

Record meetings are held weekly by the medical staff at which the residents, the interns, the record librarian and the social service director are present. At this time the records of the staff patients are reviewed and thoroughly discussed. These meetings are invaluable to all concerned and are distinctly educational to the interns.

Patients Retain Original File Number

When the record is completed, the name card is attached to the history. The following data are typed on both the face sheet of the history and the name card: hour and date of discharge, condition upon discharge and final diagnosis. Both history and name card are numbered and filed, the name card alphabetically and the history numerically. All patients previously admitted retain the original filing number which is cross indexed until after the records are numbered and filed.

The Jewish Hospital has simplified the usual system of card indexing by substituting for the cards the loose leaves in the regular history volume. One sheet of a history volume contains 400 numbers; it is headed with the name of the disease and filed according to the Massachusetts General Hospital Nomenclature. This eliminates the necessity of handling numerous cards with a consequent loss of time, and removes the possibility of their loss. Deaths are indicated by recording the history number in red ink.

The record librarian cooperates with the physicians in their research work by collecting adequate material, compiling it in a convenient form and placing it in the regulation history binder.

Out of town physicians or those not connected with the regular hospital staff, who refer patients to the hospital wards, are mailed a statement of the staff physician's findings, the diagnosis made and the treatment instituted, with suggestions as to the continuance of treatment.

The maintenance of a successful record department with an open staff does not, after all, present any unusual or insurmountable difficulties. Does not every department in the hospital—nursing, dietetic, laboratory—have the same adjustments to make in working with an open staff? It simply resolves itself into a mutual understanding made possible by personal contact and discussion.

A Nurses' Home Equipped for Social and Residential Purposes

By KATHERINE F. HEARN, R.N.

Directress of Nurses, Bloomingdale Hospital, White Plains, N. Y.

THE student nurses' house of Bloomingdale Hospital, White Plains, N. Y., was opened on November 2, 1928. It is a brick and steel structure, with wood floors laid on nailing concrete, except in places that are liable to be wet, where tile or cement is used. It furnishes residential accommodations for fifty-one students, two instructors, the house mother and the director of the school of nursing. There are also two rooms for guests.

Resources for Training Unusual

Bloomingdale Hospital is connected with the New York Hospital, New York City, and is an active center for the study and treatment of nervous and mental disorders. Its connection with the general hospital and its affiliations with other schools provide its school of nursing with unusual resources for training. In the methods employed in the treatment of its patients, much attention is given to personality study and to social training and adjustment. Such liberal provision is made for social and cultural activities, the use of arts and crafts in occupational therapy, and games, sports and entertainment as

a means of physical and mental rehabilitation that the training courses for nurses offer the student remarkable advantages for personal and social development as well as for a thorough training in general and special nursing.

How Home Was Planned

In planning the new residence for students, the opportunity for advancing these advantages was given special attention. It was felt that the residence should be a place for physical, mental and social development as well as for rest and recuperation. As the hospital was already provided with a special building for teaching nursing, it seemed best to devote the residence entirely to residential and social purposes. It seemed advisable, also, for a time at least to continue to use the present nurses' dining room which is nearer the hospital. Gymnasiums and an entertainment hall are provided elsewhere. The student nurses' house is therefore simply a home or dormitory, and an effort was made to give it something of the domestic charm and quality that is associated with a home, which is not always easy to secure in a building of this size.



Attractive outdoor porches and terraces are features of the nurses' house, Bloomingdale Hospital, White Plains, N. Y.

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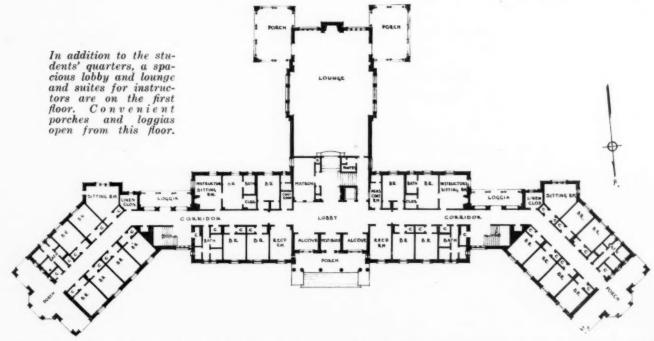
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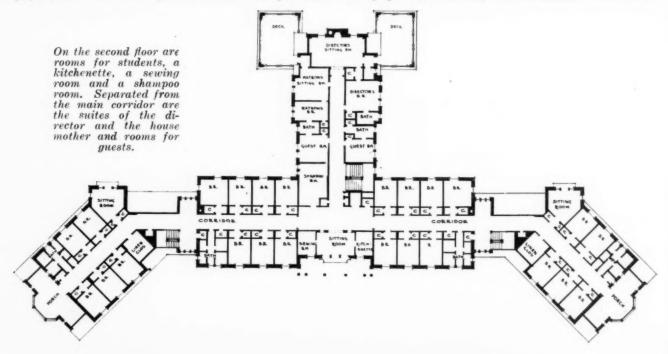
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The hospital is fortunate in having extensive grounds, which are necessary in institutions for the treatment of patients with nervous and mental disorders. It was therefore possible to select a site for the new building in a location well separated from all other buildings, elevated, with wide views and on the edge of an old apple orchard. The architect, Grosvenor Atterbury, New York, is widely known for the beauty and domestic charm of his buildings. The furnishing, with a little help from the architect, was done by Martha Washburn, the hospital housekeeper, whose fine taste and judgment had been proved in the furnishing of the staff house and cottages for physicians and the quarters for the patients.

The building faces north, toward the medical staff house, which stands 600 feet away. It consists of a central section, an east and west wing, and a central south extension. The wings connect with the central section at an angle of 30 degrees, which gives the building a crescentic appearance. This provides for the maximum of sunshine in the rooms and also reduces the long vistas in barren corridors that impair the domestic aspect of an interior. As sufficient land was available, the height of the building was limited to three stories for the central section, and two stories for the wings and south extension.

The main entrance on the north opens into a lobby paneled in oak, with a heather brown tile



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floor. Opening from the lobby are the passages leading east and west to the students' quarters; at a lower level and directly in front as one enters may be seen the spacious lounge or sitting room, which presents an inviting picture. The office, the telephone closets and the main stairway open from the passage leading to the lounge. Two alcoves in the lobby may be used for entertaining visitors. The passages to the living quarters on each side are on a slightly higher level than the lobby, and are protected by doors that are far enough from the lobby to leave a vestibule, from which open a reception room and a coat room for visitors.

At the bend in the corridors where the wing

with a sink. In each corridor are gongs that may be used as fire alarms. They can be operated from the telephone board in the hospital, and are rung in the early morning by the operator as a rising signal.

Ample Living Quarters Are Provided

At the extreme ends of the corridors on the first and second floors are screened porches which are used for outdoor sleeping. The second floor corridors are almost identical with those on the first floor except that there are no reception rooms for visitors, no instructors' suites and no long windows and loggias at the bend where the wings connect with the central section. At the



The comfortable lounge provides a pleasant place for recreation.

joins the central section is a stairway leading to the second floor and to the basement. At this point, on the south side of the corridor, there is also a battery of long windows that light the corridor and give access to a loggia with an open deck beyond. An instructor's suite consisting of a sitting room, a bedroom and a bath is in the first section of each of the corridors. The break in the corridor provides a means of dividing the students and of adding to the privacy and quiet of their rooms. This is still further accomplished by having a toilet section in each division of the corridor instead of one for the entire corridor. Beyond the break in each corridor is a small sitting room where the group can congregate informally. Each corridor contains a telephone closet, a linen room, a drinking fountain and, adjoining each toilet section, a housemaid's closet

center of the building on the second floor above the lobby is a refectory with a kitchenette and a sewing room adjoining. Here the students who are off duty may repair their garments and prepare light meals. There is also a shampoo room near by. In the south extension on the second floor, over the lounge and separated from the main stairway and corridor by a door, are the suites of the director of the school and the house mother, and the two rooms for guests.

The third floor, which is confined to the central section, contains nine students' rooms, a small sitting room and the same equipment on the corridor as on the other floors.

The basement contains, besides some storerooms, a roomy trunk room, a kitchen for use when large parties are given, a students' laundry, a maids' sitting room and coat room (there being no quarters for domestics in the building), a janitor's room and a large room which is accessible from the outside by a door at the grade level where sport and game equipment may be kept. The basement also affords access to a subway that leads to the hospital buildings and affords comfortable passage at night and in inclement weather.

The lounge or main sitting room was made large enough to meet the requirements of other developments that are contemplated, and it will eventually provide a social center for a much larger group. At the corners of the lounge on the south end are open porches with a connecting paved terrace.

Students' Rooms Well Equipped

The students' rooms are 11 feet long and 9 feet 6 inches wide, with ceilings 8 feet 6 inches high. At the entrance is a tiled vestibule on one side of which is an alcove containing a basin and a medicine closet and mirror, and on the other side is a clothes closet. The rooms are practically uniform in size and design; the windows are of the drop sash type and are made of wood and leaded sash with steel reinforcement. This type of window was found to be as cheap as the all wood type and it has the advantages of not requiring painting and of being easier to wash.

The students' rooms are simply but substantially furnished and contain, besides an iron bedstead, a dresser with a hanging mirror, a combination desk and bookshelf, a straight chair and an easy chair. There are two window shades, one of which is green, one set of curtains, two rugs, and a floor lamp that can be attached near the desk or at the head of the bed. There is a bracket light over the mirror and one over the basin in the alcove. The sitting rooms and the lounge are comfortably furnished, and special attention was given to the character and color of the fabrics employed so as to produce an effect that would be pleasing and in good taste.

The student nurses' house will, we believe, prove to be a valuable addition to the resources of the school of nursing of Bloomingdale Hospital. In its planning and development much consideration was given to the purposes it might serve, especially with reference to the personality and social behavior standards of the students. The personality and culture of the nurse are recognized to be of practical importance in the treatment of mental illness. The students' residence may be of such a character, both in its physical aspects and in its management, that it will exercise a powerful influence in shaping this part of the students' development.

Making It Possible for the Nurse to Continue Her Academic Education

Nurses who in their zeal for professional training have overlooked their academic education are being given an opportunity to remedy this deficiency in Providence, R. I., the *Trained Nurse and Hospital Review* says. This course, which was organized last year and was attended by nurses only, is offered this year as a course which any person may attend.

The course is somewhat more advanced than regular high school work and is designated as a junior college course. Subjects are offered in three units—social science, natural science and literature. Last year twenty-three nurses enrolled in the course and twenty-three finished the year. This Fall the course was lengthened by another year, making it a three-year instead of a two-year course. This will give an opportunity for electives so that students may obtain the necessary fifteen points for college entrance.

Classes are held four evenings a week. The sessions are two hours long. The first half hour is given to general discussion and the rest of the session taken up with individual conferences. Notebooks are kept in each subject.

Committee of Nine to Study Nurse Training

A report on the training of nurses has been submitted by the committee on public health relations of the New York Academy, according to the Official Bulletin of the Chicago Medical Society.

The committee brought about a hearing before the state board of regents of the University of the State of New York at which the prevalent dissatisfaction with the present method of nurse training was discussed. It was the opinion of all who spoke that the present curriculum is not sufficiently elastic and that it requires revision. At the conclusion of the conference the board of regents voted that a committee of nine be appointed with power to add to their number, consisting of three members of the board of regents, three physicians appointed by the state medical society of New York, and three nurses appointed by the New York State Nurses' Association. This committee was requested to make a study of the problem and to report on present methods of nurse training.

Dietetic Practices in U. S. Hospitals Taken as Guide in Australia

The establishment of special dietetic departments in the hospitals of Australia is expected to be a development of the near future, now that Melbourne Hospital is equipping a diet kitchen for patients who require special diets. The kitchen is to be under the supervision of Nesta Miller who has been studying dietetics in the hospitals of the United States and Canada.

To assist her in the kitchen, Miss Miller will have nurses who will at the same time be receiving training in dietetics. It is to be presumed, however, the *Prince Alfred Hospital Gazette* says, that the future development of the work in Australia will follow the practice in the United States and be separate from the nursing service.

Hospital Records and Reports and What They Should Show

By P. G. SAVAGE

Superintendent, Niagara Falls Memorial Hospital, Niagara Falls, N. Y.

THE subject of accounting methods for hospitals has engaged the attention of excellent committees of the American Hospital Association for several years. A comprehensive report with a carefully prepared chart of accounts was presented at the meeting in Atlantic City in 1926. Probably this system, as given, has been adopted in many well organized hospitals. No doubt it would prove entirely satisfactory in recording the distribution of costs and service in

methods and accounting has kept pace with their physical growth. Most accounting systems simply grow as some one individual works along from year to year and meets new requirements in his own way, as occasions demand. Consequently many offices have financial records that are comparable to the "order and system" of a rummage sale.

This condition may be deplorable and then again it may not be so serious. Such a criticism does not imply that records without much system are inaccurate. The accounts and records of practically every hospital are audited annually and the financial report is a true statement of the receipts and disbursements. How much more may be gathered from hospital reports depends wholly on the skill and enthusiasm of the individual who makes the report.

Without question it would be highly desirable

NTHLY COMPARATIVE STATEMENT TO CORRESPOND WITH COMMUNITY CHEST SUDGET REPORT

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the majority of modern hospitals. It was stated at the outset, however, that the accounting system of a hospital should be simple. Otherwise, the cost of maintenance is often prohibitive, especially in many of the smaller hospitals.

No one particular accounting system has been accepted as suitable for hospital service. With the rapid expansion of all hospitals in the past it is doubtful if the perfecting of bookkeeping

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if all hospitals used a uniform method of recording financial data. Such data would be of value for a comparative study of hospital conditions from year to year. But to attempt this now would be unprofitable. An old hospital adding from 50 to 100 per cent to its capacity and service also adds many new phases to the work of the office. Until the accountant has had an opportunity to search out the new applications of this service he may have a set of records that are valueless for purposes of comparison.

Varying Policies and Procedures

Another phase of the subject that causes some alarm in the matter of securing uniformity is the variance of policies and procedure in different hospitals. Some institutions enter items for depreciation each year and some do not. Special funds are applied for charges that would otherwise appear under general costs. Government aid of one kind or another, allowances, special privileges and other considerations, all tend to modify the uniformity of a general covering system of financial reports.

The separation of operating accounts, however, might well be given the careful attention of every hospital executive. With the great increase in hospital business and the larger public interest in hospital affairs a thorough analysis of these

expenditures is highly desirable.

Another factor that has brought special attention to hospital accounts is the participation of hospitals in community chest funds. The allotments to the various agencies are made after the presentation of budgets based on past performance and expected needs. Those who have this arrangement know the usefulness of well prepared reports that show with fair accuracy how the expenditures have been made and how the same or additional amounts will be required. No hospital is likely to require less money for any coming year than it has required in previous years, and the more convincingly this situation is set forth the better the chances are for support from community funds.

The real purpose of all accounting and financial reports is to give immediate and accurate information in the most understandable manner. Hospital executives should strive to improve their accounting systems and they should regard kindly those changes that will bring about uniformity and establish reliable sources of comparative

studies.

What should these records and reports show? At least a monthly review of all income and expenditures in a classified form; an intelligible record that may be studied satisfactorily by the

members of the hospital board of directors; an analysis of the costs and losses per patient day; any extraordinary receipts or expenses; the status of outstanding accounts and unpaid bills; a comparative record with the previous month and the accumulative record on the year's budget estimate. If all of this is done successfully the administrator will have the whole-hearted interest of the members of his board. It is most likely, also, that he will be able to secure any assistance he wishes in reducing extravagances and misdirected efforts.

This matter of accounting is a large and comprehensive subject. Those who prepare annual financial reports for the state board of charities are aware of the intricacies of such reports and they know they must strive for the simple form if they would serve the best ends of hospital practice. The business side of these institutions, far greater in scope than any business project, must be made comparable with good business organizations. Excellent attention must be given to the accounting practice of the hospital—accounting, not for the production of fine records, but to make use of the information gained to develop and advance hospital service.

The Value of an Appeal Man to the Hospital

In planning a campaign for funds it is essential that an absolutely honest examination of the whole problem be made, an article on hospital appeal work in the Hospital Gazette points out. Not only the good points but the weaknesses as well must be listed. A plan of campaign in which an appeal man is included must then be evolved.

"In this initial formulating of plans, the value of an experienced appeal man is twofold," the article continues. "He will not only know what can be undertaken but he will also know what to leave alone. The preliminary investigations may suggest in one case that the problem can best be solved through the activities of local committees; in another, a postal campaign may suggest itself; in a third case, it may be decided that little headway can be made until the work and needs of the hospital have been made known through a publicity campaign.

"Two principles that may be regarded almost as axioms are, first, that if the hospital concentrates on raising money for capital expenditures, there will be a decrease in the general maintenance funds and, second, that there is practically no appeal value in the cry of so

many thousands of dollars in debt.

"While the relationship between costs and results cannot be neglected, it is essential that a broad view be taken before judgment is passed. The first year, for example, of regular appeal work may show poor results mathematically. Subsequent years, however, may prove this initial year to have been a firm foundation for many successful years' incomes."

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Advertising Occupational Therapy

By ETHEL C. DANA Washington, D. C.

DURING the period of the World War medical men who were connected with the service were brought into contact with occupational therapy and had an opportunity to observe the therapeutic benefits derived from this form of treatment. As a result, after their return to civil practice many of them had become so impressed with occupational therapy as a valuable aid to medicine, that they urged its establishment in the hospitals under their care.

In this manner it has come about that there are two groups of people who have come in contact with this form of treatment, but only one of them, the medical group, or those who prescribe and administer it, have a real understanding of its scope. Most patients realize only that they are pleasantly occupied, that time does not drag too heavily and that their minds are diverted from their troubles. They have little or no insight into the intent and purpose of the prescription that controls their movements. After a season they return to their daily occupations, forget the contact with occupational therapy and become merged into the great third group, the general public.

Scientific Articles Lack Appeal

The members of the general public seldom read scientific articles in medical journals, or even articles with unfamiliar titles in popular journals or newspapers. The heading "Occupational Therapy" fails to attract the average reader. Thus, the problem is to find a way to appeal to the curiosity of those people whom we wish most to reach

The medical service of the U. S. Veterans' Bureau has requested from the hospitals from time to time, projects and case histories showing the therapeutic benefit derived from prescribed occupational therapy. In 1925, these records were exhibited, so that the public might be brought in touch with the progress of this now well developed form of treatment.

In 1926, at the national sesquicentennial exposition in Philadelphia, the U. S. Veterans' Bureau had an exhibition in which occupational therapy activities were emphasized. The byproducts there displayed were selected by the medical service as representative examples of

types of occupational therapy as administered by the Veterans' Bureau. The display was interesting and much of the fine handwork attracted the visitors' attention.

Appeal to the Imagination

An occupational therapy aid was on duty to explain the purposes of the exhibit, to point out the various case histories connected with it, and also to make plain that the articles there exhibited were only by-products of prescribed doses of "work cure" or occupational therapy. The idea was to arouse interest by appealing to the imagination of the average person, to give a human touch to the exhibit by bringing him into contact with the intimate details of another's life. Everyone likes to hear a good story, particularly if it is a true story. Therefore, occupational therapy was presented from a practical rather than a scientific point of view, as a popular short story with all the illustrations at hand. The results were satisfactory. Many visitors came to inspect the exhibit and many of them returned a second time with friends who were interested. The officials of the exposition were impressed and the jury of awards conferred upon the United States Veterans' Bureau the gold medal "For demonstrating the health value of occupational therapy."

After the exhibit at the sesquicentennial exposition was closed, it was believed by the director of the Veterans' Bureau that this method of reaching the public should be continued to illustrate further the application of and the results from occupational therapy, as administered in the Veterans' Bureau hospitals all over the country. The exhibit was enlarged and extended by combining it with that formerly set up by the medical service, and it has been placed in Room 1007 in the Arlington Building, Washington, D. C., which is the official headquarters of the United States Veterans' Bureau.

Attendant "Tells the Story"

As at the sesquicentennial exposition, there is an occupational therapist in charge who is ready "to tell the story." If the visitor is attracted to a well made fern stand, his attention is directed to other articles made by the same patient, which

form a collection illustrating a year's treatment. The first ugly vase-shaped article, made of reed, which the patient called a wine jug is pointed out, and a short resumé is given of the patient's condition at the time the article was made. Next is described his hyperactivity followed by seasons of depression, which made him always a disturbing element on the ward. Then it is explained how this was corrected by craft work, which furnished an outlet for his motor activity and brought him into contact with his environment. Three pieces of reed work, each one more regular and artistic than the previous one, illustrate the change in the mental attitude. As the patient's mental state improves, he is taught to weave, and a scarf made just before his discharge is neatly and attractively done, and the patient is quiet and cooperative showing an interest in ward activities and in other patients.

Patient's Progress Indicated by Work

Thus, the visitor learns how occupational therapy helps to bring the patient to the point where he can be discharged and returned to useful citizenship. Or, with the help of four cards on which progressive work is mounted, the visitor is shown how the level of a deteriorated case has been raised, the perseverance involved in the approach, the time which it has taken to instill the idea of directed effort and concerted action and the result—two strings of wooden beads, red on a red string and blue on a blue string. The other three cards, each displaying the result of three months' progress, and the last showing a well made rag rug, represent the result of a year's work of one patient.

All this cannot fail to bring to the visitor a realization of the care and thought with which occupational therapy is prescribed and the patience and sympathetic understanding with which it is applied.

Method Proves Successful

The hospitals in the field are invited by the medical service to send in from time to time interesting by-products, or perhaps a series of them, made by patients who are benefiting from their prescriptions, together with a complete medical history of their progress. In this way the exhibit is renewed. A neatly framed sign in the doorway of the Arlington Building announces to the passerby an "Occupational Therapy Exhibit."

By this method the Veterans' Bureau is advertising occupational therapy, and from the goodly number of visitors registered since the opening of this room, it is believed that this method of advertising is successful.

The Duty of the General Hospital to Borderline Mental Cases

That borderline mental cases could be handled, during the beginning period at least, in a general hospital where all diagnostic aids are within easy reach and the facilities are complete for giving prompt and efficient medical and surgical treatment, is the thesis of a paper by Dr. Edward J. Engberg, St. Paul, Minn., prepared for the Minneapolis Medical Journal.

Doctor Engberg also emphasizes the part that is played by psychiatrists in private practice in treating those who are suffering from mental disease. Many physicians assume that if a patient develops a psychosis, the outlook for recovery is unfavorable and that he should be committed to the state hospital at once. Doctor Engberg further points out that 52½ per cent of all patients in all hospitals in 1928 were in those for mental and nervous disease. The general recovery rate for the country per 100 admissions was 13.6 per cent; 27 per cent were discharged as improved.

Borderline cases should first be admitted to a private hospital for the sake of accurate diagnosis, Doctor Engberg believes. Otherwise, there is danger of nonpsychotic patients being committed to state hospitals because of the lack of facilities for proper study in the general hospital. It is important, too, that members of the family know whether the condition is a psychosis, because of the part inheritance plays in the occurrence of mental disease.

What a St. Paul Hospital Has Found

Although there is necessarily a great difference of opinion among medical authorities as to whether or not psychiatric patients should be treated in a general hospital, the neuropsychiatrists on the staff of a large hospital in St. Paul, Minn., which has accepted such cases for more than twenty years, agree that thoroughly satisfactory treatment may be given in a general hospital, provided there is a special department and the treatment of the psychiatric patients is limited to the neuropsychiatric staff. Within the last ten years, this hospital has treated 1,854 psychoses, 313 alcoholics and 57 drug addicts. A group nursing plan is in effect, by which graduates especially trained in psychiatric nursing are employed by the hospital. The patient is charged a rate for the room that is only slightly higher than the price of the average room on the general floor. As soon as the patient's condition improves, he is moved to a room or ward on the general floor at the same rate charged the general medical or surgical case. A full-time director of occupational therapy and recreation is employed.

Doctor Engberg concludes his paper with the following sentiments: "A day will come when no general hospital will be considered measuring up to its needs that does not provide a suitable department for the treatment of patients with mental symptoms, either as an integral part of itself, or through close association with such a hospital.

"Modern medicine has advanced rapidly in recent years but the treatment of mental disease has not received the recognition that such a big problem deserves. It is hoped that physicians and hospitals will become sufficiently interested to provide every facility for the adequate treatment for those afflicted with mental disease. It is to be hoped that general hospitals will in the near future recognize the importance of providing well organized departments for the treatment of such patients, equal to the standard of all other departments. Then and then only can it be said that medicine is advancing symmetrically in all its realms."

Citrus Fruit Juices—Nature's Gift to the Hospital Dietary

By LULU G. GRAVES

Consultant, New York City

SINCE fruit has become an essential part of the hospital menu the provision of fresh fruits during the winter months often presents a problem. This is particularly true of the hospital in a district remote from large markets or of one in which the finances do not permit of out-of-season foods. It is in instances such as these that dietitians are grateful for citrus fruits.

Citrus fruits have an odor and flavor so refreshing and so stimulating that they are well adapted to the menu of the sick. They are always popular with the personnel of the hospital, and they are so universally liked they can be used in some form for any meal of the day.

Juices Are Important in Dietary

The dietitian's first thought with regard to oranges and grapefruit is to serve them for breakfast. It is usually at this time that the appetite of the patient needs the greatest indulgence. There is an increasing predilection for the juice of the fruit only at this meal. For the breakfast served on a tray this is particularly desirable. The juice has all the virtues of the whole fruit, except the cellulose, takes up less room on the tray and is more easily manipulated. For the individual whose fruit must be cold in order to be pleasing, the juice can be more easily served on ice than is possible with the whole fruit.

For luncheon and dinner, gelatines, ices and numerous other desserts made with orange juice are always welcome. Practically any combination of fruit juices is improved by the addition of orange, lemon or grapefruit juice.

The value of citrus fruits in the dietary is well known. The juice is an essential factor in liquid and soft diets, its value in anorexia is an accepted fact and frequently for those whose diet should have a limited sugar content, it will satisfy a craving for a sweet without the introduction of an inordinate amount of sugar. The relief that orange juice gives after a dose of bitter medicine needs no comment.

All of the commonly accepted vitamins are present in oranges. Vitamin C, the antiscorbutic

vitamin, is the vitamin that is most commonly associated with oranges. Its presence in large amounts is of such value that Sherman' says, "better growth, higher stamina and better health and disposition are induced by the feeding of vitamin C in the form of orange or tomato juice." Oranges and orange juice contain vitamin B and an appreciable, although not a large amount of vitamin A. Grapefruit and grapefruit juice are credited by Sherman with the same vitamin content as Doctor W. D. Sansum, Santa Barbara Cottage Hospital, Santa Barbara, Calif., also recommends the use of fruits, fruit juices, milk and vegetables in the diabetic diet as a means of preventing high blood pressure. He reports that diet will remedy abnormally acid urine and that he has treated a series of fifty cases of high blood pressure. In all of these he was able to produce a neutral urine and in 90 per cent of the cases the blood pressure fell forty or fifty points.

Some physicians are now requiring their patients to take large quantities of orange juice prior to an operation in which ether or chloroform will be used, since the alkali introduced into the system helps to prevent postoperative troubles.

Water Content Is Important

A point that is sometimes lost sight of in the consideration of fruits is their contribution of water. Americans have the reputation of not drinking enough water. Any food that helps materially in making up this lack should be given credit. Citrus fruits contribute this element.

The prejudice against the use of orange juice and milk at the same meal has long since been removed. Chaney² in a feeding experiment in the Claremont Public School, Berkeley, Calif., used oranges and milk for the midmorning lunch. She says: "Milk and oranges taken at the same time appear to stimulate growth at a level slightly higher than milk or orangeade alone, but not so much as do oranges. Oranges, as fed to the children in this investigation, seem most efficacious in producing a gain in weight. This may be due to the vitamin content of the orange."

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The use of acidified milk in infant feeding as an aid to digestion and as a preventive of scurvy is an accepted therapeutic practice, especially in specific disorders. It is conceded that milk modified by the addition of acid has the advantage of greater convenience in preparation over bacterially soured milk. Hess and Matzner³ recommend the use of citric acid for this modification, having thoroughly tested tomato, orange and lemon juices. If proper precautions are taken, orange or lemon juice can be added directly to the milk without curdling it. Its true acidity in the stomach is made to resemble more nearly that of human milk. It is more digestible and it supplies the antiscorbutic vitamin that is deficient in other than raw milk.

Orange Juice Excellent for Children

Another notable study of the value of orange juice in the diet of children is that of Morgan, Hatfield and Tanner⁴. They found that, both in height and in weight, greater average gains were made by the group of children fed orange juice than those made by the groups fed either milk or figs.

Oranges contribute more than their own properties to the body; they help the body to assimilate the elements introduced by other foods. An experiment showing this was carried out at the University of Chicago. Children were given from twenty to twenty-three ounces of orange juice a day-two to three cups. Their gains in weight were greater than could be accounted for by the calories in the oranges. Also the amount of the bone building lime and phosphorus retained in the body was larger than that imbibed in the orange Magnesium and nitrogen retention was also increased. This means that oranges, besides adding their own minerals to the body, help the body to utilize those from other foods. Although these studies were made with children, the results are no less important for the adult. The patient, medical or surgical, is a subject for diet therapy until his recovery.

A good quality of juice may be obtained now in bottled form. Until recently the bottled products were not entirely satisfactory. A newly developed high vacuum process, however, seems to have overcome the previous defects. By this process the fresh orange or grapefruit juice is sterilized without affecting the concentration. It has the same vitamin, mineral and solids content as the fresh product. The color, flavor and aroma are excellent because it is made from tree ripened fruit. These characteristics are retained as long as the bottle remains unopened and for two or three days after the bottle is opened, provided it is kept in a cold place. Bottled grape juice of this quality has been available so long that it is taken for granted. No doubt the same will be true of citrus fruit juices. Citrus fruit juices packed in containers other than glass are apt to suffer from a chemical reaction with the metal. This has been found to be true even in lacquered cans. Until further improvement in these containers has been made, it is advisable to forego the use of them.

Serving grapefruit for breakfast in a hospital usually calls for its preparation the previous afternoon or night because of the time required for the work. With the bottled juice this is avoided as is also the deterioration that takes place in the cut fruit overnight, not to mention the general overhauling of the refrigerator necessary to make room for the many halves of grapefruit. Since these bottled products have had no sugar added, they may be used for calculated diets, diabetes, nephritis, epilepsy and other conditions, thus eliminating no small amount of the work of preparation.

Juices Acceptable for Hospital Staff

Because interns, dietitians, nurses and others of the hospital personnel must of necessity live a more or less sedentary life, proper nutrition is of importance to them. The serving of cereal once and meat twice daily to these members of the hospital family is a common practice. Bread, potatoes and other starchy foods are apt to be eaten in too large quantities unless the menu provides adequate quantities of vegetables and fruits. Meats and starchy food materials have an acid reaction in the body. Citrus fruit juice has an alkaline reaction. The body chemistry should be alkaline in reaction and citrus fruits are efficient in keeping it in that condition. Bottled orange and grape fruit juice make possible so great a saving in time and labor that these beverages may be served to the staff with comparative frequency. A food that is high both in palatability and in food value is a solace to the dietitian.

Any device that saves time and labor in the hospital kitchen is generally accepted with alacrity by the dietitian. Serving all "nourishments" from the kitchen is becoming a common practice, and when this is done bottled orange juice is of real service.

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Keeping Patients Comfortable by Means of the Health Room

By ALVAN L. BARACH, M.D.

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THE health, comfort and efficiency of individuals exposed to the hot and humid weather characteristic of the summer months in the most populous sections of the country may be impaired, at times seriously, by the abnormal physical conditions of the atmosphere.

Human comfort depends entirely on the relation between the rate of heat production within the body and the rate at which heat is removed. The body loses heat to the atmosphere and surrounding objects by radiation and convection as well as by the evaporation of moisture from the surface of the body. If conditions of the atmosphere are such that heat is not carried away by air movement or by evaporation at the same rate at which it is generated, discomfort is experienced and at times health is endangered.

The American Society of Heating and Ventilating Engineers at the laboratory of the Bureau of Mines, Pittsburgh, has conducted a long series of experiments to show the effects of high temperatures and humidities on comfort and various standards of physiological efficiency, such as pulse, blood pressure, basal metabolism, temperature and weight.¹ These effects will be briefly outlined.

The Effects of the Tests

Still, saturated air at 91.5° F. resulted in a definite rise in temperature, moderate increase in pulse rate, profuse sweating, weakness and dizziness. Five subjects who sat for an hour in still, saturated air at 95° F. were all decidedly distressed. The body temperature rose to 101.5 to 102.5. The pulse was fifty beats above normal with a fall in both systolic and diastolic blood pressures. Weakness and exhaustion were pronounced. At 100° F. in saturated air, the effects were still more marked, with a fall in diastolic pressure but a rise in systolic pressure. The pulse rate became elevated to 135 to 184 beats per minute. The subjects who entered the room in

a happy mood soon became restless and irritable. They complained of headache and palpitation of the heart. The headache soon became throbbing and the palpitation grew distressing. Great thirst was experienced. The eyes became inflamed and sore. A feeling as of a weight on the chest was noticed. The voice suffered, and speaking became an effort. Dizziness and confusion followed. After leaving the room the subjects found it necessary to rest for five or ten minutes before taking a shower. Weakness and a tired feeling continued for some time. A metallic taste in the mouth was a noticeable symptom, and persisted for one or two hours following exposure to the high temperature. The conjunctivitis was found to be due to the sweat dripping into the eyes.

The Value of a Cool Atmosphere

The symptoms that have been described begin in saturated air at a temperature of 90° F. With lower humidities greater temperatures are necessary to produce the same effects. Although these temperatures are relatively uncommon, moderately increased temperature and humidity are frequent during the summer months. effects of less marked humidities and temperatures are more difficult to measure quantitatively during short periods but they are none the less causes of fatigue, discomfort and illness when present over longer periods of time. Heat prostration and heat exhaustion occur frequently during the summer months, particularly in the very young and in the old. Adults who are engaged in physical work are also prone to collapse. Many others who fall short of collapse are handicapped in work as well as in comfort by the interference with the elimination of heat which is induced by high humidities and high tempera-

Any febrile illness during hot weather imposes an additional severe burden on the mechanism that attempts to rid the body of heat. In the use of oxygen tents and oxygen chambers in the treatment of pneumonia and allied respiratory disease at Presbyterian Hospital, New York, one of the striking sources of subjective increase in

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¹ McConnell, W. J. and Sayers, R. R., Some Effects on Man of High Temperatures; Reports, Department of Interior, Bureau of Mines, Serial No. 2584, March, 1924; Sayers, R. R. and Harrington, D., Physiological Effects of High Temperatures and Humidities With and Without Air Movement, Public Health Reports, Vol. 38, No. 29, July 20, 1923, Reprint No. 584.

comfort was the provision of a cool atmosphere.¹ Frequently, when the patient was no longer in need of oxygen it was difficult to remove him from a cool atmosphere because of the feeling of distress that a warm humid air imposed upon him. In postoperative conditions, particularly in hyperthyroidism, exophthalmic goiter and toxic adenoma, in which an increased heat production is characteristic of the disease, a cool atmosphere is of genuine importance. An operation on a patient with exophthalmic goiter during the hot weather definitely lessens the chance of an uneventful recovery.

Finding Comfort in the Health Room

The presence in a hospital, home, apartment or office of a room that can be ventilated to produce optimum conditions of comfort by maintaining suitable temperature and humidity, during winter and summer, has the advantages that have already been pointed out. The room, conveniently designated as a health room, may be employed as a workroom, as a living room or as a bedroom. During the hot humid weather it will be the place to gain comfort and a feeling of well-being.

In addition to the mechanism for cooling and drying the atmosphere, the apparatus may be equipped with a mechanism for moistening and warming the air during winter. The cold outside air that is admitted to rooms in winter contains moderate amounts of moisture, but when it is heated by steam or hot water radiators the relative humidity falls, frequently as low as 20 to 30 per cent. This superheated, dried air is irritating to the mucous membranes and is probably partly responsible for the many affections of the respiratory apparatus that are so common in winter. The outside air may be low in temperature but the humidity is relatively normal. Indoors we are exposed to abnormally dry air.

The health room possesses an additional feature that is of great importance to sufferers from hay fever and from asthma caused by dust. The air, in addition to being modified in its temperature and humidity, is freed from dust. Filters that remove most of the large and medium size dust particles as well as pollen are provided. Since all the air, even the outside as well as the recirculated air, is passed through filters, it is free from both dust and pollen. A table in the room for several days collects no dust, illustrating not only the cleanliness of the room but also the completeness of dust removal. Hay fever sufferers would be free from symptoms as long as they remained in such a room. Even if they

were compelled to go to business part of the day, they would at least have the evenings and nights in a room in which they could secure rest and sleep.

There is considerable evidence now from the reports of patients in dustfree rooms abroad and in this country that patients suffering from asthma caused by dust become and remain comfortable in such rooms.¹ During both winter and summer patients suffering from other diseases, such as arthritis, high blood pressure, heart disease and chronic bronchitis, are greatly benefited by the removal of distressing atmospheric conditions.

The idea of a health room grew out of the increased comfort that was obtained in a new type of oxygen chamber constructed at the Presbyterian Hospital, in which temperature and humidity were subject to independent automatic control.2 By the use of brine circulating in pipes and air finned steam radiators, the atmospheric air was modified in its temperature and in its content of moisture. The use of a humidostat and a thermostat rendered the regulation of the ventilation in the chamber automatic. It seemed feasible to have the room equipped with a unit apparatus that could be installed in any hospital, hotel, office building and apartment. Such rooms were considered valuable in all communities in which abnormal temperature and humidity conditions prevailed during some period of the year.

A Brief Description of the Apparatus

With the cooperation of an electric company and an engineering company there has been devised and installed an office consulting room of this character. The principles involved have already been suggested. The details of construction may be more properly outlined in trade journals. In brief, a relatively closed system of ventilation is provided by circulating the air in and out of the room by one-foot square ducts after first closing the windows, lining the room walls with insulating board and weatherstripping the doors. Refrigerating machines are used to cool water which is pumped to an apparatus in the bathroom outside the office. In hot weather the air is drawn from the room, blown over a series of coils containing water at 42° to 47° F., passed through a filter over steam coils, which may or may not be employed as desired, and enters the room cooled and dried. Before the air is passed over the cold pipes, an admixture of 10 to 25 per cent of outside air is added to remove tobacco smoke and to freshen the recirculated air.

² Barach, Alvan L., THE MODERN HOSPITAL, 32, No. 1, 1929.

¹ Barach, Alvan L., Journal of the American Medical Association, 87, 1213, 1926; Journal of Clinical Investigation, 2, 463, 1926; The Modern Hospital, 32, No. 1, 1929; New York State Medical Journal, 29, 989, 1929.

¹ Leopold, S. S. and Leopold, C. S., Journal of the American Medical Association, 84, 731, 1925.

The apparatus has been employed in our office during the hot humid weather with marked increase in comfort. We have kept the temperature ten to fifteen degrees lower than the outside air whenever the temperature went above eighty degrees outside, with a humidity of approximately 50 per cent. The work of the consulting room was more agreeably pursued than it would have been in a hot humid atmosphere. Furthermore, the cool atmosphere provided comfort in the evening when the outside air caused marked discomfort.

A room of this kind, conveniently designated as a health room, appears to us to have a real value for hospitals and sanitariums. The distressing and at times harmful effects of hot, humid weather may by this means be prevented, at least in part. For cases of hay fever and dust asthma especial relief from symptoms may be afforded.

Righting the Injustice to the Chronically Ill*

A book that is forcibly bringing to the attention of the medical and hospital world the injustice that is being done to many patients disabled by chronic ailments has recently come from the pens of Dr. Ernst P. Boas and Dr. Nicholas Michelson, New York City, on "The Challenge of Chronic Disease."

Doctor Boas and Doctor Michelson have condensed in a volume of 190 pages, including a bibliography, much thought stimulating information concerning the needs of the chronic patient. Insofar as the facilities for his care are concerned, it is conceded that the chronic patient has less to challenge either our interest or our scientific inquisitiveness than has the more dramatic and, in many respects, more interesting acutely ill patient.

When the battle between the invading organism and the body's resistive forces becomes a stalemate, chronicity results. Perhaps it is the very duration of the illness, practically changeless in its clinical aspect, that produces a sociologic apathy on the part of the public generally, and a medical indifference on the part of physicians, specifically.

Unfortunately, the resources of the patient are likely to be exhausted before a successful issue in the conquest between disease and the body's natural resistance is reached. Hence, the financial requirements made upon a family for the care of one of its members with a chronic disease are often so great that outside help must be sought. But to secure effectual aid in such a dilemma is usually difficult.

The classification that the authors make in regard to the types of chronically ill patients is largely drawn along lines dependent on the amount and variety of medical and nursing care required. An attempt is made to differentiate certain types of chronic disease due to degenerative processes in contradistinction to those produced by the wear and tear of the passing years. Such classi-

fication is not particularly useful as an aid in solving the problem. It is about as easy to search successfully for agents that will cure chronic disease as it is to find the long lost fountain of youth. The end results of the presence of chronic disease and of the wearing out of tissues are the same—disability and finally dependence.

Chronic ailments, because they destroy earning power, place upon the community an economic problem which, after all, is as much its duty to solve as is the care of those acutely ill. Hitherto, the care of such patients has been left to institutions supported by public funds. Comparatively few private hospitals in this country have well organized and well conducted chronic departments.

It would have been heartening had the authors discussed the relationship between an improperly supervised convalescence and a preventable chronicity. Too many hospitals for the treatment of acute diseases, in their desire to shorten the average hospital stay of the patient, are, to a certain extent, preventing the proper adjustment of the patient's bodily chemistry thus making it difficult for him to pass successfully the period of convalescence and to evade the danger of chronicity.

Another danger to be avoided is the voluntary pauperization of those who are handicapped. That dread disease which comes from too long hospitalization and which is expressed in a lack of desire to become self-supporting again is almost as resistant to treatment as the actual presence of tissue pathology. Prevention of chronicity is certainly much more efficient than its cure.

Concerning the best means of caring for those afflicted with chronic disease, the authors suggest pensions for the aged and infirm, sick insurance and some interesting but apparently idealistic considerations relative to the prevention of poverty. The latter can be brought about only when there can be a standardization of many of those personal traits of industry and economy that are as intangible and as difficult of cultivation as are most other human character traits.

It is wholly commendable to stress the desirability of preventing insofar as posible, the hospitalization of patients suffering with chronic disease. In some cities are to be found associations that exist for this purpose. The Orphans' Guardian Society of Philadelphia, for example, has endeavored for years to keep intact the home circle and to prevent its disruption by disease produced poverty or by poverty produced disease.

Preventive Measures Needed

The authors discuss the structural and administrative requirements for a hospital for chronic diseases. While many practical considerations that differentiate the conduct of the chronic from the acute hospital are set forth, this chapter might have been somewhat abbreviated without detracting from the force of the dissertation. As we have with us the poor, so shall we always have about us those suffering with chronic disease. There will be a never ending army of the handicapped knocking at the doors of our country's institutions, and while the chronic patient is, perhaps with some justice, an anathema to the acute hospital, yet one must plead for sanity and humanitarianism insofar as the handling of this type of patient is concerned.

With the development of a newer understanding concerning the cause of chronic heart and kidney disease will come preventive steps that may remove many hundreds of these cardiac cripples from our acute and chronic hospital wards. To be sure, disease due to senile and presenile states must be considered, for the time being at least, outside the reach of the scientist.

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^{*&}quot;The Challenge of Chronic Diseases," Ernst P. Boas, M.D. and Nicholas Michelson, M.D. The Macmillan Company, New York, 1929.

Hospital Changes and Developments in Foreign Countries

A Department Conducted by E. M. BLUESTONE, M.D. Medical Director, Montefiore Hospital, New York City

ANUMBER of structural changes are taking place in the old hospitals of London. St. Bartholomew's Hospital, which is the oldest hospital in the country, having been chartered by King Henry I, is completing a new surgical block and operation theaters. This block will contain ten wards with accommodations for 250 patients. The estimated cost of the buildings and equipment is \$1,000,000.

The building, which will be ready for use January 1, 1930, is constructed of five floors, each floor having two wards—one for male patients and one for female patients— connected by means of a middle corridor with an operating theater in a separate block. Each ward will contain twenty-two beds, one double room and one single room for separation purposes. There are also provided on each floor a demonstration room, a dark room and a waiting room for friends of the patients. On the topmost floor of the building are the new clinical laboratories for the medical and surgical professorial units and for the surgical units. On the roof above this is a covered section for the use of the patients.

The building is said to be of modern construction throughout and is designed for eventual connection with the existing south block so that a corresponding medical and surgical unit may ultimately be placed on the same floor. The position of the surgical in relation to the medical wards is held to be of material importance, since it is considered essential that there shall be means of direct communication between the physicians and the surgeons of corresponding units.

Five Large Operating Theaters

A block containing five large operating theaters with the necessary anesthetic rooms, rooms for the surgeons, the dressers and the nursing staff, sterilizing rooms and storerooms, is adjacent to the ward block and is connected with it by corridors so that each surgical unit may have a pair of wards and the accessory suite of rooms and corresponding operating theater. The operating theater has, in addition, a gallery for students

from which may be obtained an excellent view of the theater. Access to this gallery is provided by a separate staircase. On the lower ground floor of the block is the sterilization department which communicates with the various floors by means of a special elevator for the purpose of conveying instruments and surgical dressings to the operating theaters. Provision has also been made for an x-ray theater for use in conjunction with the wards.

New Out-Patient Department for St. Thomas's

For some years the governors of St. Thomas's Hospital, London, have been considering the possibility of erecting an out-patient department on the site that they purchased in 1919 across the street from the hospital. According to Sir Arthur Stanley, treasurer of St. Thomas's, the chief obstacle to this plan was the provision of adequate communication with the hospital. authorities were unwilling to permit the construction of either a bridge or a tunnel, and in the latter case the cost would have been almost A scheme, therefore, has been evolved which, if it can be carried out, will make St. Thomas's the finest hospital in Europe, with the most up-to-date methods of treatment in all branches of the out-patient department. In this department 600,000 treatments are now given yearly.

It has for some time been recognized that the medical school buildings, which are continuous with the hospital on the Albert Embankment alongside the Thames River, facing the Houses of Parliament, could in many respects be improved. It was also obvious that the best position for the out-patient department was on the site of the present medical school. It could be linked up with the main hospital by prolongation on the ground floor corridor, thus removing all difficulties as to communication. In contrast to the existing out-patient department, which borders on Lambeth Palace Road and echoes incessantly the noise of the trams and other heavy traffic, the new out-patient department could be so devised

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that all its rooms would face north, south or west and would enjoy that quietness that is necessary for the proper examination of patients.

December, 1929

Plans are now being prepared both for the new out-patient department and for the new medical school.

An American wing will be added to Charing Cross Hospital, London, early next year with funds that are now being raised in New York City by Philip Inman, governor of the hospital. Mr. Inman, in describing the plans of the American wing, has announced that American financial support already has been given in generous measure to build the wing, and that three \$5,000 bed endowments have already been pledged.

Among those who have pledged their support, according to Mr. Inman, are Sir Thomas Lipton, J. Wright Brown, Sir Joseph Duveen, Dorothy Gish, Dr. S. Parkes Cadman and the National City Bank.

The plan for an American wing for Charing Cross Hospital has been inspired by the success of the American Hospital at Neuilly, Paris. The increasing number of Americans visiting London has emphasized the need for a special institution to care for those requiring medical attention. Americans who were admitted to Charing Cross Hospital totaled 117 in 1925, 133 in 1926, 129 in 1927, and 178 in 1928.

Increase in Number of American Patients

The increase in the number of American patients is due for the most part to traffic accidents. Americans visiting London are unaccustomed to the traffic regulations requiring vehicles to keep to the left and from force of habit get into difficulties which end in the hospital.

Work has already been started on the wing. The wing will cost \$150,000 and probably \$200,000 if its capacity is increased to forty beds. It is Mr. Inman's plan to raise \$150,000 as an endowment, making a total of \$350,000 for the American wing fund.

King George V is patron of the Charing Cross Hospital, H.R.H. Princess Louise is president, and the Earl of Lonsdale is treasurer.

"Of the thousands of American visitors in London," Mr. Inman is quoted as saying, "a large proportion during their sojourn in the metropolis are within the working zone of Charing Cross Hospital. Among such a mass of people are numberless cases of sudden sickness, surgical treatment and traffic accidents. Hundreds come into our hospital for treatment. They are not charged a penny.

"Charing Cross Hospital is in the center of the London hotel and theater district and is a protec-

tion to all. Its work is not national; it is international. It is out of debt and extension of its work is not undertaken until means for extension are in sight. Two years ago we needed \$1,250,000 to extend our premises so that we could cope adequately with the ever increasing number of street Of that amount the English people accidents. have given \$1,100,000, but in collecting that sum our subscribers have been bled white. still a balance of \$150,000, which is urgently needed.

"Charing Cross Hospital was the educational birthplace of two of the greatest supermen: the missionary, Dr. David Livingstone and Prof. Thomas Henry Huxley, the great biologist."

Mr. Inman has been governor of Charing Cross Hospital for ten years.

Valuable Booklet on Fire Prevention Is Issued

The National Board of Fire Underwriters has made the September-October issue of its Laboratories' Data the hospital fire prevention number. This issue contains a collection of articles on fire prevention by persons who have devoted themselves to a thorough study of the sub-The review of the statistics concerning hospital fires reveals several points of significance to hospital administrators who will undoubtedly profit by a perusal of the data that have been here compiled. The booklet should serve as a guide in making hospital inspections and as a means of acquainting the superintendent with the hazards that may exist in his institution.

Some of the subjects touched upon in the booklet include: hospital fire hazards; electrical safeguards in hospitals; hazardous properties of cellulose nitrate and acetate films; combustible anesthetics and devices for their administration; the hospital service of the Western Actuarial Bureau; hospital and institution fires; the smoke and fume hazard of "safety" x-ray film; automatic sprinkler protection for hospitals; electric motors for use in flammable atmosphere.

Because the subject is approached from various angles and because the suggestions offered are practicable, the booklet should be a valuable addition to the library of the hospital administrator.

A Hospital That Is Twenty-Five Years Older Than the United States

Pennsylvania Hospital, Philadelphia, was receiving patients twenty-five years before the birth of the United States in 1776, John N. Hatfield, assistant superintendent, points out in a letter to THE MODERN HOSPITAL. Pennsylvania Hospital is still operating on a charter granted by George II of England, in 1751, Mr. Hatfield says, and it is now in its 179th year. The hospital was first founded through the efforts of Benjamin Franklin and he was the first secretary of the board of managers and the second president.

Practical Administrative Problems:

How to Make the X-Ray Department a Financial Asset

By JOSEPH C. DOANE, M.D. Medical Director, Jewish Hospital, Philadelphia

SINCE various phases of the work in the x-ray department have been discussed from time to time in THE MODERN HOSPITAL, this article will deal primarily with the practical angles of the scientific and economic aspects of the x-ray department in the general hospital.

Slightly over a quarter of a century ago the use of the x-ray was in its infancy. For a number of years, the employment of the x-ray was confined largely to the study of diseases of and the results of trauma to the bony structures of the body. Until some opaque and physiologically inert substance was discovered by which functional as well as anatomic diseases could be studied, the uses of the x-ray were rather restricted. To-day, most hospitals possess in some degree x-ray facilities for the diagnosis and, in many instances, for the treatment of disease.

In the large hospitals with ample means it has not been difficult to develop ample x-ray facilities. In the great majority of small hospitals, departments adequate for the diagnosis of fractures and even for the performance of certain grades of fluoroscopy are usually found. On the other hand, even with the refinement of this apparatus and with a substantial reduction in price, the result of competition as well as of the development of greater knowledge concerning production methods, it is still impossible for some institutions to obtain sufficient funds with which to purchase efficient roentgen ray equipment.

X-Ray Facilities Should Be Available

It is difficult indeed to answer the question as to the size and type of hospital in which x-ray facilities are indispensable. It may be said, however, that wherever an attempt is being made to treat sick men and women in a modern way, access to x-ray facilities is usually necessary. What is to be done, therefore, in the small hospital when sufficient funds are not available either for the purchase of the apparatus or for the recompense of a trained personnel? Under these circumstances, it is possible that some system of

group responsibility for providing such equipment could be worked out. Yet, no arrangement can be satisfactory in which delay must be encountered when an x-ray study is required. This is true because the physican or surgeon so frequently demands this specialty information immediately. Hence, sufficient time is rarely given either to call for aid from without the hospital or to enable any extra-mural apparatus to be of effective service.

Choosing a Place for the X-Ray

It may be said, however, that since an efficient portable or bedside unit can be bought for approximately \$1,000, no institution need be without such equipment entirely. It must be granted, therefore, that an x-ray department, no matter how rudimentary, can be considered something in the nature of an absolute requisite in the equipment of the hospital.

It is interesting to note the diversity of locations that have been selected by hospital directors as suitable for the housing of this important division. In many hospitals, it has been felt wise to place the roentgen ray department in quarters adjacent to the operating suite. This, it appears, is a logical situation because of the necessity for the frequent location of foreign bodies as well as for the treatment of fractures under the fluoroscope. If this be the place selected, some arrangement should be made by which it is possible to avoid the confusion and crowding on an operating floor incident to the study of patients from the wards and rooms of the hospital, as well as those sent from the dispensary.

In some hospitals, this requirement has been met by placing this department on the ground or first floor with easy access to the operating suite by elevator and to the rest of the hospital by corridor. It is regrettable that in so many instances, there has been chosen for this important activity a location whose only virtue seems to be that it was little used for any other purpose. As a result, the x-ray director and his co-laborers often

work under insanitary and, at times, even dangerous conditions. Ample room should be provided for the prosecution of this work, with at least the same provisions for light and ventilation that one expects to find in a workroom in the industries. It is regrettable but true that the hospital, standing as it should stand for the best in personal hygiene and preventive medicine measures, frequently requires its workers to labor in surroundings that would not be permitted in the most carelessly conducted factory or shop.

Fire Hazard Must Not Be Forgotten

In locating the x-ray department, it should also be remembered that a certain fire hazard always exists in this work. The hospital world has reverberated for the past few months with comments relative to a recent catastrophe which, while not caused entirely by a faultily located film storage room, was certainly aggravated by this fact insofar as the loss of life was concerned. The x-ray department certainly should not communicate with floors above by means of elevator or pipe shafts. And this is said with a complete knowledge of the safety factors vouchsafed by the use of the cellulose-acetate films.

No matter how much confidence one rightfully places in the use of nonexplosive films, the storage of large quantities of these records in a building occupied by patients, or even adjacent to such a building, is ill-advised. Moreover, the accidental admixture of acetate and nitrate films has been known to take place. Experienced hospital administrators for years have been preaching against the use of combustible or explosive films. If any considerable quantity of exposed or nonexposed films must be stored, a concrete vault, perhaps with an explosion or loosely attached roof and built at some distance from the main hospital plant, seems to meet all safety demands.

The equipment of the x-ray department will depend largely upon the type and volume of work that are expected from it. The most meager equipment in the smallest and most impecunious hospital will certainly provide the essential roentgenographic needs and, possibly, will provide for the performance of some fluoroscopic studies. The routine in all well run departments consists not only in the exposure and devolpment of films, but also in confirming and elaborating these findings by the direct inspection by means of the fluoroscope of the organs and tissues being studied. Frequently, in the small hospital the same transformer is used for the performance of fluoroscopy as well as of roentgenography. A properly constructed overhead wire system makes it possible so to manipulate the electric terminals that these

two procedures can be carried out from the same machine.

There have been great refinements in the manufacture of the x-ray tables in the past decade. As a result, radiography can be performed in one of several positions with hardly any inconvenience to the patient. Fluoroscopy can usually be done by the use of the same table. In such a department in a small hospital, a room perhaps 14 by 16 feet should be sufficient for the proper housing of this equipment. To be sure, the most meager requirements should provide for a control stand which is so enclosed that protection to the health of the operator can be continuously provided.

Whenever fluoroscopy is to be done, a toilet and a dressing room adjacent to the machine room are convenient. In larger hospitals, a separate room frequently is assigned to each of these activities and often a separate transformer is provided. In some institutions, the construction of the dark room seems to have been an afterthought. Its entrance often is not safeguarded against light and the room itself is frequently so small that the technician is handicapped in her work. A properly constructed shutter which will allow ventilation without light is of the utmost importance. Sometimes this consists of but an opaque material, such as one sees in well made window curtains, so arranged that it slides from a roller through lateral slots, thus allowing for the elevation of the window sash and for the elimination of light. This latter arrangement is simple, inexpensive and fairly efficient.

In the small hospital, if stereoscopic work is to be performed, it is of course necessary to provide a film changer and usually a Bucky diaphragm. It appears rather difficult for proper dental work to be performed by the use of an ordinary x-ray table.

A Splendid Opportunity for Cooperation

Some institutions have been greatly concerned about the advisability of purchasing a deep therapy machine. Such a machine, costing usually from \$5,000 to \$6,000, represents a colossal investment for many institutions. If the institution has a capacity of 200 beds or more, if it conducts an active surgical service in which there is considerable likelihood that malignancies will be frequently encountered and if there are in the community no other machines of this type to which such patients could be referred, it seems advisable for this major investment to be favorably considered. Here is a splendid opportunity for cooperative effort on the part of the hospitals in any town or city. A cancer service might well

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be instituted on the basis of a community need and the treatment of malignancies, preoperative or postoperative, could be carried out by one institution while the remainder of the group contributed towards its purchase or at least towards its maintenance. It would seem inadvisable for more than one institution in a community, although it might represent many thousands of inhabitants, to purchase such equipment. Moreover, it seems to be a development of the last quarter century to look more and more upon the care of the sick as a community problem, and to consider as ill-advised the unnecessary duplication of specialty equipment and personnel by a number of hospitals. The days of competition in hospital work are fast drawing to a close.

Ample Waiting Room Space Necessary

It is not necessary in this sketch to endeavor to make any more definite statements as to the arrangement of the hospital x-ray department except to emphasize that ample waiting room space should be provided and that, as is frequently the custom, hallways adjacent to this department should not be looked upon as the proper place for stretcher and ambulatory patients to congregate while awaiting their turn to be studied. Because safety measures that are necessary to protect operators and patients from the dangers incident to the use of high voltage electricity have been discussed in recent issues of THE MODERN HOSPITAL, particularly those for February and June, 1929, it should be sufficient here to remark the necessity of covering floors with rubber or some other substance that will serve as an efficient nonconductor. It might be a wise step to protect the operator fully against suits for damages or malpractice although the eleemosynary nature of the hospital probably covers this point.

Almost all of the reputable distributors of modern x-ray apparatus offer a competent service covering the planning and arranging of the x-ray department in the new hospital. If this aid cannot be secured, advice from an experienced hospital administrator is sometimes wisely sought.

One of the most difficult problems that confronts the hospital executive is to determine the best method by which the x-ray department should be administered. A study of hospitals throughout the country reveals a great diversity of systems of administration. As is often seen in the other specialty departments of the hospital, there does not appear to be sufficient work therein to require the full-time service of a skilled roentgenographer. In many small hospitals and in not a few larger ones, attempts have been

made to solve this problem by engaging a parttime director. In some communities where there is a paucity of well trained x-ray physicians, a curious situation has arisen by which one x-ray specialist may serve more or less satisfactorily as director of the departments of at least a half dozen hospitals. In a certain Eastern city, this situation was actually and numerically found to exist.

It does not seem reasonable to suppose that a physician, conducting a private office of his own for the study and treatment of disease by x-ray, could find sufficient time or energy in the course of the day to spend an adequate number of hours within a half dozen institutions. But a mere time requisite is but a part of the problem. In addition, the director must furnish both the technical skill and the scientific stimulus that should be expected from a department as specialized as is this one. When such a situation exists, it is usually found that the smaller and less opulent hospitals have been glad to attach the name of a well known roentgenologist to their staffs and yet have not been able to supply a sufficient honorarium to command much of the director's time. As a result, the hospital does not receive a great deal of benefit from this arrangement.

It is difficult, therefore, to define accurately the duties and prerogatives and at the same time properly to estimate a just recompense for that specialist, the x-ray director. There has grown out of this dilemma a great confusion as to the best method by which the physician supervising the hospital roentgen ray department should be paid for his services. In addition, there are practical problems to be solved, such as the proper financial understanding as to the purchase of supplies, the hiring of technicians and the most efficient system for the collection of fees, as well as the settlement of such difficulties as to the best means by which emergency night and holiday work can be secured.

Providing an Efficient System

What, then, are the possibilities of providing a system that promises prompt service from the x-ray department when the director of the department may be engaged at that time at any one of several other hospitals, or may even be concerned with his own private practice? Mention has already been made concerning the number of hours of a director's time a hospital requires. This must be wholly dependent upon the size of the hospital and the type of work it carries on. In addition, the number of members of the resident personnel, as well as their degree of skill, will determine in a large measure the amount of

December, 1929

service required from a visiting and nonresident director.

There is another angle to this problem that is highly practical. When an x-ray specialist is conducting within the community a private office for the prosecution of his specialty, he is, in reality, placing himself in competition with the institution from which he receives an honorarium, small though it may be. This difficulty frequently is enhanced by the fact that the rate card issued by the hospital, is often slightly higher than the prices charged by the director himself in his own office. Hence, it is perfectly natural for referring physicians, having learned of this state of affairs, to send their patients for study to the director's private office rather than to the hospital.

Various Kinds of Arrangements

When this pernicious system is further developed, the director sometimes receives a certain percentage of the gross or net income resulting from the activities of the department, in return for which he is expected to give his services, to furnish certain supplies, including x-ray films, and at times to pay the salary of a technician. It can be readily seen, under such circumstances, that the free work requested by staff members immediately becomes a financial liability to the director, and that it is to his advantage economically to keep within the lowest possible bounds the number of films used on ward patients.

In some instances, a special arrangement exists between the hospital and such a director by which the institution pays the cost price for every ward patient studied or treated by the Usually the hospital is expected to furnish, under this arrangement, the x-ray apparatus, heat, light and janitorial service and to keep the department, including its equipment, in repair.

In some hospitals, particularly those of a hundred beds or less, in which a roentgenologist is found whose time is largely consumed by other hospital and personal appointments, the absurd plan has developed whereby the x-ray director spends no time at all at the hospital. True it is that in certain situations, the director possesses a staff of one or more assistants whom he dispatches to the hospital when he is told that an x-ray study is required. Any system is inefficient that depends upon each needed study being made an emergency that demands a telephone call for help from without the hospital. So important is the use of the x-ray in modern hospitals, that such studies should be routinely possible at any hour of the day or night. The presence of a

resident officer who possesses sufficient ability only to expose the film and who must dispatch it to a distant director's office for development and report by telephone represents, as has been remarked, an absurdity in procedure. Yet this arrangement is observed in various guises in many of the hospitals in the field.

This leads to a more concrete discussion of methods by which the director should be paid. The x-ray department should be not only a scientific asset but it should return to the institution a rather substantial profit. There are two main systems in vogue by which the x-ray director is paid. The first, and without question the most advantageous to the hospital, is one that represents the payment of a flat salary to the director, which commands a sufficient number of hours of his time so that the x-ray department is able to contribute its full share to the work of each hospital day. The amount of such a salary depends, of course, upon the skill of the roentgenologist, the number of hours required and the size of the hospital. Such a salary may vary from \$3,000 for four hours of service a day to \$10,000 or \$15,000 a year for full-time service. Fortunate, indeed, is the hospital whose size and finances permit the employment of a full-time director at a living salary. Here the problems arising from a real or potential competition between the director and the hospital are obviated.

Instances Illustrate Varied Plans

It seems, however, that this arrangement is the exception rather than the rule. A number of actual instances will now be mentioned to illustrate how varied, and often how improper and unfair to both parties are the plans now in use in some of the hospitals in the field. In one instance, a hospital of 125 beds pays a part-time director who spends two hours a day in the institution, 50 per cent of the gross income for his services. The director received from this hospital \$1,200 in a recent year. The gross cost of this department was slightly in excess of \$1,100 in the year under consideration, and in this institution 540 film exposures were made. It requires but a slight amount of computation to learn that the cost per film in this hospital approximated two dollars. Here this activity actually represented a financial liability rather than an asset, since the year's work showed a real deficit. In another hospital doing about the same bulk of work, the cost per exposure averaged less than a dollar.

In another institution of less than 200 beds, the films are exposed by a technician and sent to the office of the director for development. The technician divides her time between the pharmacy

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and the x-ray department. In this particular hospital, the director furnishes both the supplies and the technician and receives in return all the fees from private patients, while the hospital maintains the department and keeps the apparatus in repair, at the same time furnishing heat, light and janitorial service. Moreover, the director receives a cost plus 25 per cent fee for all work done on ward patients. No more careless, inefficient arrangement could be imagined than is this. In this particular institution, the x-ray department represented a financial loss for each year's work insofar as the hospital budget was concerned. In still another institution, the roentgenologist receives the entire income from full-paid studies, but does the clinic work free.

How the Director's Income Is Computed

Some hospitals compute the payment of the x-ray director upon a net income basis, this ratio usually representing an equal division of these monies between the director and the hospital. Again, there are institutions that allow the roent-genologist to collect 50 per cent for all private fees, while fees from clinic and ward patients are appropriated by the hospital. And finally, there are institutions that collect all the fees for the roentgenologist, retaining 10 per cent of these fees for this service.

It will be quickly seen from the foregoing instances that no standard practices have been adopted representing the most logical and businesslike arrangement between the head of this department and the institution he serves. It seems that the hospital should refrain from adopting any plan that contemplates the development of films outside the institution. No hospital that permits any member of its personnel to function in absentia can furnish a full and scientific service to a community. The stimulus that arises from the consultation of other staff physicians with the x-ray director and from their discussions of their clinical problems in the light of the x-ray findings is most desirable.

It has been intimated that a flat salary basis appears to be the most logical, although in certain instances it appears that a percentage basis serves as a stimulus to enlarge and to increase the scope and activity of the department's work. The hospital should certainly furnish all supplies as well as the salary of the x-ray technician. An increase in free work should not represent a financial liability to the director. If this type of arrangement is adopted, a percentage of the net income of the department might be a fair basis upon which to proceed. It ought to be understood, however, that if a major expenditure for

repairs or replacements becomes necessary and the director is not at fault, the hospital should meet such an obligation. If 50 per cent of the net income is not adopted as a standard, a somewhat less fraction of the gross income might be used as a basis of computation.

However, the former arrangement, with perhaps a guarantee by the hospital of a minimum annual income to the director, would be as fair an arrangement as any. In the smaller institution, a flat salary for the part-time director with a bonus for a bulk of work over and above a certain amount is sometimes considered a logical method of payment.

It seems perfectly reasonable for the x-ray technician to be assigned to some other work in the hospital, provided her full-time services are not needed in this department. But in the hospital's resident personnel, there should be someone who possesses sufficient ability not only to expose but also to develop and read emergency films. This person may be a resident physician or a resident medical head of some other department.

There are many other practical problems that concern themselves with the functioning of the x-ray department. Interns should not be given carte blanche in ordering studies, irrespective of their number and cost. Surgeons frequently establish a definite routine which interns are permitted to follow in the absence of their chiefs, although it would probably be better even under this arrangment for some check on these requests to be made by a resident medical officer. The use of the x-ray department, however, should not be so encumbered by red tape that free access to its facilities is discouraged. It is of the utmost importance for all fractures and head injuries to be considered as x-ray emergencies.

Business Practices Are Necessary

It is not possible to lay down any rule relative to the comparative expense and income of such a department. In some large institutions, each x-ray exposure costs from eighty cents to a dollar. In smaller institutions, this unit cost may run much higher. In one hospital of 125 beds, the annual outlay for the x-ray personnel is about \$6,000, while supplies, including films and chemicals, amount to approximately \$2,500. This department showed a net profit of \$1,100, or 13 per cent, in 1928. Many institutions are experiencing greater financial returns than is this one although the hospital in question is to be congratulated upon the conduct of its department.

There is another criterion by which the care in ordering x-ray studies can be more or less gauged. Where negative reports are too high in comparison to the number of studies made, one should infer that an insufficient and hurried clinical study has been made. The x-ray should be often confirmatory rather than wholly diagnostic.

Sufficient has been said to denote not only the importance of the x-ray department as a scientific asset of the hospital but also the desirability of its representing a decided annual financial benefit. Every aid should be given the director to enable him to formulate definite conclusions from his studies. Important points in the history of the patient should be included upon the x-ray request. The x-ray study of disease should not represent a kind of contest between clinicians and x-ray workers as to the demonstration of their relative diagnostic abilities. The diagnosis of disease is a cooperative venture. The clinician, who looks to the x-ray department for a diagnosis on his patient, is frequently deceived. Indeed, even with the refinement in x-ray technique that has come with this day and age, it still must often serve simply as an arrow to point out possibilities rather than to make diagnoses with certainty.

The x-ray department of the hospital, therefore, has much to contribute to the institution and its community. It should be the purpose of the board of trustees to bring this service within the reach of all economic classes, and any tendency toward exorbitancy, in the fixing of rates, should be avoided. Nevertheless, with the most reasonable of charges but with the installation of businesslike principles in the keeping of records of expense and income accounts, the x-ray department should never represent a financial loss to the hospital. This latter statement is perhaps made too emphatically, but its truth is demonstrable if the pitfalls represented by unbusiness-like practices are avoided.

Concerning the Tariff on Hospital Equipment

This paragraph concerning tariff on surgical and dental instruments and hospital equipment appeared in a recent issue of the Journal of the American Medical Association:

"The committee on finance of the Senate has tentatively agreed to recommend to the Senate that the duty on surgical instruments remain as it is under the present tariff act, at 45 per cent ad valorem and the duty on dental instruments at 35 per cent ad valorem, instead of being increased to 70 per cent and 60 per cent, respectively, as provided by the tariff bill passed by the House of Representatives.

"The committee has approved, however, the proposed increases in the tariff provided for by the House of Representatives' bill on pharmaceutic, surgical and scientific

articles and utensils used in hospitals, laboratories and colleges, wholly or in chief value of glass, from 65 to 85 per cent ad valorem, and in the duty on ophthalmoscopes, corneal microscopes, testing or recording instruments for ophthalmologic purposes, colorimeters, hemacytometers and other instruments of the same class from 45 per cent to 60 per cent ad valorem.

"Physicians, hospitals and colleges desiring to protest against the proposed increases, which presumably will in the end be reflected in the cost of medical, surgical and hospital care, should write or telegraph their respective senators and the chairman of the Senate Committee on Finance, Washington, D. C."

The Health Problem and How It Is Being Solved in New York City

The health problem in New York City is complex, but in no city in the United States are there so many agencies devoting themselves to the solution of this problem, a directory issued by the Welfare Council shows. The council is a federation of more than 700 welfare organizations.

Handling the health problem in New York are 263 hospitals, 1,410 clinics, 112 baby health stations, thirty-six health administration and education organizations, twenty-seven nursing services, sixty-seven institutions for convalescent care and 146 services for mental hygiene. In addition the directory lists 133 prenatal clinics, 120 dental clinics, eighty-nine ear, nose and throat clinics and so on down the scale of twenty-five special services dealing with the health of the citizens.

The directory shows 300 organizations engaged in family welfare work, 250 child welfare agencies and more than 300 organizations in recreation, education and neighborhood activities. About 6,000 persons are connected with the various agencies.

When Is the Best Time to Raise Money for the Hospital Deficit?

It is easier to raise money to meet the hospital deficit during the early part of the fiscal year than at the close, the Western Hospital and Nurses Review discloses in a recent article on raising money to meet hospital deficit. If the funds are raised at the beginning of the year it is easy to get away from the word deficit and to speak of the fund as money needed to carry out a certain constructive program the hospital had planned.

"When money is solicited for the education of nurses, the relief of the sick poor or similar activities, the solicitation has a personal appeal, and all kinds of facts and interesting human touches can be marshaled for the support of a campaign that is raising funds for these activities," the article says. "It is a mark of sound management and of sound planning to have the funds in hand or at least pledges for such funds before proceeding with the work. In raising funds afterward to meet the deficit for operations that have already taken place, the person's approval of a definite program is not sought. He is simply asked to pay the bill.

"Asking for the intelligent support of a philanthropic individual of a well planned program appeals to him as investing money in human beings."

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Editorials

When Are Statistics Vital?

M ORTALITY statistics are valuable in direct proportion to the accuracy of the certificates of death from which they are compiled. Even under the most favorable circumstances, these documents are very likely to be but perfunctorily executed.

The difficulties that physicians encounter in arriving accurately at a diagnosis of the nature and location of disease are many and are often insurmountable by even the most skilled. Any pathologist who has an opportunity to compare at the autopsy table the postmortem findings with the antemortem clinical diagnoses will attest to this fact. Under optimum conditions, as a result of the exercise of the diagnostic knowledge and technique of able and experienced hospital physicians, these findings may coincide accurately in from one-half to two-thirds of the cases coming to autopsy.

Now, when it is remembered that the country's statistics as to the causes of death are based not only on hospital reports, but also in some places on those of medically untrained coroners, health officers and even ignorant and careless clerks in minor governmental offices, the gross inaccuracy of available vital statistics becomes even more glaringly apparent. In the case of a hospital death, the certificate is often executed by the intern. The staff physician, having exerted every effort to save life, is rarely present. Amidst the discouragement at the demonstrated futility of drugs and surgery to restore health, the young physician, particularly early in his intern course, is inclined to view the writing of a death certificate as a necessary but more or less unimportant bit of official red tape. Uncertain as to the exact nature and location of the lesions producing dissolution, he cloaks his ignorance with a grandiloquent "chronic myocarditis," "acute cardiac dilatation," "bronchopneumonia" or some other term that he knows will be accepted by the local registrar.

To be sure, three score and ten, or even a less measure of years is sure to leave some myocardial scars and bronchopneumonia is often a terminal condition. As yet, clinicians to-day, more than ever are looking with suspicion on acute dilatation of the heart as a frequent cause of death. To one who has ever observed an ignorant and unlettered coroner's jury gravely rendering a ver-

dict that an unfortunate man or woman had died from natural causes, chief of which was heart disease, comes the natural query as to whether, after all, cardiologists are building too strongly their incidence statistics on such worse than useless suppositions as these.

'Tis an obligation which the hospital should not consider lightly to endeavor faithfully to add to the sum total of human knowledge concerning the cause and cure of disease. There are at least two methods at its command by which this can be done—the prosecution of the most accurate and painstaking scientific study of the patient's condition during life and the careful postmortem examination of the bodies of those whom disease has overcome.

Modest indeed is the requirement that 15 per cent of all hospital deaths must come to autopsy. No hospital staff should feel content unless the bodies of at least one-half of all patients dying in the institution are so examined. Even when a commendable number of postmortem examinations are performed, hospital administrative machinery is often so cumbersome that the death certificate is not subjected to a final correction before being forwarded to local health authorities.

The death certificate is an important official document. It must not be altered to conform to the rules of insurance companies or to the wishes of the family of the deceased, as is sometimes done in the case of death from alcoholism or venereal disease. To distort willfully the medical truth on any record is dishonest and worse than cowardly. To search slothfully for the hidden cause of death is to brand an individual or an institution as unworthy of the confidence of the living. To regard carelessly the need for more accurate vital statistics is to deserve the charge that the hospital and its executive are unfaithful in no small degree to the community's trust.

Annual Report of Hospitals

IT MAY lacerate the tender sensibilities of some of the hospital world but there is a truth that must be told with brutal frankness, and right now. It is this: Most annual hospital reports are a needless waste of paper, ink, effort, envelopes and stamps.

When one digs up a hospital report that deals in encomiums of the board of trustees, particularly those who are dead or who have been heavy handed contributors during life, and proceeds to a general alibi for the hospital superintendent and his chiefs of departments, with a few dry vi-

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tal statistics interlarded, and finally closes with a blank bequest form—if one's patience has lasted out reading that far, he comes to the conclusion that the reading is utter bunk—and so it is.

Some reports are printed and illustrated with lavish prodigality; others are badly printed on the flimsiest of paper and consist largely of a whine for more money. Should not the hospital field in justice to itself undertake to lay down a basic policy regarding hospital reports? There are only a few people who are interested in morbidity and mortality statistics. Very few people care to read over a table showing the religious beliefs of the patients treated. Only the medical staff is interested in the statistics touching upon the various diseases and injuries for which patients were treated, and nobody but the board of trustees cares for a list of the securities held and their present book value.

It is suggested that the first thing in a report should be a statement from the board of trustees detailing exactly what it has accomplished during the past year and setting forth in plain language its program for the coming year. This idea should be carried through the reports of the hospital superintendent, the superintendent of nurses and the heads of the other departments. In other words, the report should show what each of these people has done, and should set forth a program of projects to be carried out. A report prepared in this way will be read. It will be of value to those who read it, whether they be laymen or professional workers. After all, a hospital is a business institution and its reports should reflect sound business policy and accomplishment.

Misplaced Emphasis

THE Committee on the Grading of Schools for Nurses has already accomplished much that is commendable and all in all much worth while. It has focused the attention of the hospital field and of the public generally on many problems, basic in importance. It has collected and published data, both interesting and unique in manner of presentation.

But are not the public and nurses themselves tiring of the continuous flashing on the screen of warnings as to the danger (chiefly to the nurse herself) of overpopulating the country with graduates for whom no calls for service will come, for whom there is no economic, social or scientific need? Who but the nurse herself determines that the members of her profession huddle in cities where the ratio of nurses to lay population is already too great. The law of supply

and demand will decide this problem just as it will deter too many young women from entering normal or other specialty schools if the profession of teaching is overcrowded or underpaid. What of the great unexplored field of public health and industrial medicine? Will not the future need for nurses in these activities, as their possibilities unfold, consume some of the excess of graduates whose economic existence is so much in doubt?

It is probably true that schools are graduating nurses more rapidly than the public is now able or inclined to employ them. But would it not be better to employ less printer's ink in deploring the probable fate of the unemployed nurse and devote more energy to the problems as to how the greatest curative and preventive medical and nursing service can be rendered to the greatest number of people? On with the actual grading of schools! A halt on the broadcasting of gloomy prognostications as to the dangers the future holds for the nurse whose services are a glut on the market. The former is practical and necessary. Time will care for the latter.

Ethics and Economy

ECONOMY should be the watchword of every hospital organization. To waste time or effort, food, gauze or rubber goods while conducting the hospital is more than an economic sin. To allow costly apparatus to deteriorate as a result of neglect is to be guilty of an infraction of the cardinal institutional law of conservation.

A laudable desire for economy, however, does not permit an executive to disregard the rules of ethics or decent dealing which underlie all human contacts in the business world. It is more than necessary, moreover, for the superintendent of a hospital to preserve his business balance and to maintain his ability to recognize relative values in service, morale and ethics in the light of the major or minor outlays of money necessary to secure their presence. To save money but to lose the confidence of associates or supervisors or the respect of self is the most shortsighted of policies.

To save at the spigot and waste at the bunghole has long been the quaint but expressive description of the adoption of such ill-advised practices. Nor does the existence of an urgent necessity for economy justify the adoption of any semblance of sharp dealing. The borderline of unsound ethics must never be crossed. Moreover, the fact that the hospital is a charitable institution does not justify its superintendent or its board in assuming the rôle of community alms

gatherers. To request donations from those nearby whom the hospital stands ready to serve is fully justified. To request contributions from dealers who furnish the institution with necessary supplies and equipment is a practice subject to improper interpretation and one which is neither businesslike nor wholly ethical. members of a business firm who are residents in the community will usually desire to support the cause of the hospital whether or not they are favored with its business. But if all supply houses that are prepared to furnish any of the many articles necessary to the hospital were expected to contribute to the support of all institutions that buy from them, the cost of hospital goods would reach impossible levels.

The quid pro quo, as far as the expenditure of the hospital's funds is concerned, must be honest goods at fair prices. No other service or bonus can rightfully be demanded of firms with which the hospital trades. Moreover, the implication, whether implied or direct, that those firms that contribute to the hospital will be placed on its list for further orders of goods represents a grossly unethical act. Such a policy, while not wholly identical with the practice of soliciting petty graft as observed in public purchasing, nevertheless suggests unfair competitive methods and strongly smacks of a business procedure that is questionable if not actually dishonest.

Talking It Over

OF ALL the days of the year, Christmas claims the greatest prominence in the hospital world. No matter what the creed, the birthday of the Gentle Master, the day which marks the rising of the Sun of Hope, the day which means good cheer, good fellowship and warm hearts, is celebrated in every hospital. The manner of celebration is a great problem as it is sometimes exceedingly difficult to decide the extent to which the celebration may go. Of course there is the feast with the increased dietary but this, alas, is not available for all patients. There are the entertainments, the carols, the Christmas trees but unfortunately not all patients are benefited thereby. The sick man who is making a desperate fight for life does not consider "Many happy returns of the day" as exactly tactful. Every patient, though, is a child and even the simplest gift is much appreciated if it be surrounded by the Christmas spirit. The spiritthat's the thing. The most lavish gifts and entertainment fall dead as ashes if given perfunctorily; even the simplest toy is highly valued if the spirit of cheer and love surrounds it.

A BOVE all, let Christmas be for the patients. Too frequently, it is a show for outsiders. Patients resent being photographed for the press. Christmas isn't the time for getting things for the hospital; it's the time for the hospital to give things. It isn't the time for publicity;

"Hospital Gives Christmas Entertainment" isn't news; it's an attempt to capitalize on what should be a beautiful spirit of generosity and good will. It shouldn't be advertised any more than a Christmas tree in a private home. Christmas is getting too highly commercialized, anyway.

CHRISTMAS is the time of peace, the day when worry should be utterly banished. The sight of the hospital personnel fretting about decorations and stewing over petty details isn't the Christmas spirit. Everybody is giving of himself in order that the patients may have merriment; let the giving be merry, untainted by worry and fussing. We can't have a real yule log, that green log during whose burning nobody had to work, but we can revive the customs of our forbears—the carols certainly, the trooping of the swan, the baron of beef when possible. Wassail has gone but pine, holly and mistletoe remain.

THE holly berries are the blood of Baldi, slain by the innocent Mistletoe, which perpetuates in its berries its own tears for its deed. Mistletoe is the most important of the medicinal plants used by the Celts. It was their "all heal" which gave life, cured unfruitfulness and protected against poison.

CHRISTMAS in pagan times was a festival to revivify the inspiring sun and to express joy at the slowly returning light. To the Christian world it symbolizes the return of light for a soul-weary world. Let it to the hospital world signify the ardent and expectant hope of a return of health and happiness.

THE political hospital superintendent is a person who sits on the fence with his ear to the ground and tries to keep his nose on the grindstone.

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HALF a century ago railroads transported baled hay in open flat cars. Fires frequently occurred and every caboose carried hayhooks with which to throw off the burning bales. Finally, closed cars were substituted for flat cars but hayhooks continued as a part of the equipment of cabooses until some keen railway executive stopped the practice. How many hayhooks have you in your hospital?

IN ALL games of skill, such as tennis and golf, there is a technique of play that is called form. This merely means that the player, by concentration, has learned how to avoid mistakes to the point where his method of play is subconscious. Many self-taught players never acquire form even though they employ a teacher to eradicate their faulty habits. There is a form in everything technical which man does. This applies particularly to the hospital field. The worker who would be really competent must be well taught and then must concentrate to the point that form is automatically subconscious.

Guérir quelquefois
Soulager souvent,
Consoler toujours."

This is a sentiment which should prevail in every hospital.

"Sometimes cure,
Frequently ease,
Always comfort."

Your Everyday Problems

A department devoted to the informal discussion of problems arising in the everyday life of the hospital superintendent.

[No attempt has been made to offer final conclusions relative to the questions considered in this department. The Modern Hospital will gladly welcome further comment by its readers on any of these problems, or the presentation of other queries for discussion in later issues.—Editor.]

What Is the Most Efficient Way of Administering Oxygen to a Pneumonia Patient?

The hospital buys oxygen in various sized tanks of both a high and low pressure. For use in combination with nitrous oxide in the surgical clinic, oxygen in somewhat different capacity tanks and pressure is purchased as compared with that employed in the medical and surgical wards for the administration to patients showing cyanosis from whatever cause.

The common custom in most institutions is to use a 100-gallon low pressure tank for the latter purpose, with a water bottle and sufficient hose to render the transmission to the patient convenient. For the actual administration to the patient, a small sized catheter or nasal tube is usually employed or else a cone of small proportions is simply held over the patient's nose and mouth. This latter method of administering oxygen is inefficient and is often annoying to the patient. By the cone method, the patient inhales but a small percentage of the oxygen used. The administration of this gas is usually of short duration because of the necessity for some person to stand at the patient's bedside to hold the cone. The catheter or nasal tube method is somewhat more efficient but at its best unsatisfactory.

There have been developed in the last half decade, a number of apparatuses for the administration of oxygen. Beginning with an oxygen room into which gas, generated nearby, is poured at a regulated concentration, this procedure has developed so that there are on the market a number of satisfactory portable and relatively inexpensive machines for the constant administration of oxygen. The oxygen room has been fairly satisfactory but is of little use to most institutions because of the expense in its construction, and also because of the relatively small proportion of time it is in use during the year. Instead of placing the patient's bed within an oxygen atmosphere, it has been found practicable to construct an oxygen hood which fits tightly enough about the patient's head and shoulders so that little of the gas escapes. To this principle, have been added such refinements as a rebreathing process with the separation of the CO2 gas from the contaminated oxygen air by the use of lime salts.

Certain apparatuses have also taken advantage of the principle of the salubrious effect of cold air upon the pneumonia patient, and have forced by means of a small electric fan, the purified air with its added oxygen content through a chamber of ice. In the hands of one who understands the functioning of such an apparatus, a

pneumonia patient can be kept for a number of days in an oxygen concentration of about 45 per cent, and at the same time, be free from any sense of constriction or suffocation because of the presence of the tent. Such apparatus is certainly life-saving and has many advantages over the tank, bottle and tube apparatus, or even over that which employs a mask similar to the one commonly seen on the gas machines. It is possible to use a commercial oxygen in the apparatus described, and the cost averages about \$2.50 to \$3 per 1,300 gallons. Such an apparatus employing 40 per cent concentration and using two to three liters per minute will last, dependent somewhat upon the accuracy with which the flow is gauged, from twenty to twenty-six hours. effect upon a toxic cyanotic pneumonia patient of the exemplification of the foregoing principle is dramatic. The lips and countenance become pink and the patient experiences a feeling of well-being.

What Precaution Should the Hospital Take in Handling Cases of Influenza?

Since the great influenza epidemic in 1918, the existence of disease conditions simulating true influenza has been sporadically reported in scattered localities in the United States.

The minds of lay persons, and even the minds of physicians, appear to be much confused in regard to the nomenclature covering such infections of the respiratory tract. As a result, the terms grip and influenza are used interchangeably. It is doubtful that any considerable number of cases of true epidemic influenza have occurred in the United States in the last decade. As winter approaches almost every locality is visited by a quasi-epidemic of catarrhal affections, ranging from the ordinary pharyngitis and rhinitis to a severe bronchitis that terminates in bronchopneumonia. Local physicians usually style the milder types of this sort of infection, "grip."

In the last six months, there have occurred in the United States a considerable number of cases that resemble influenza in their clinical history as well as in their tendency to be actively contagious. Boards of health everywhere are rightfully alarmed as to the possibilities of a recurrence of this dread disease in epidemic form and have requested that these cases be reported by physicians and hospitals.

The chief difficulty lies in accurately and certainty making a diagnosis. In the absence of epidemic influenza, scattered mild cases could easily go unrecognized. The converse of this statement is equally true. Scattered cases rarely exist without quickly presenting localized epidemic manifestations.

When a number of patients with the classical symptoms of true influenza are brought to the hospital, the staff must be on the alert to recognize and report the disease and to provide immediate treatment. When such cases

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are discovered, isolation from noninfected patients is certainly indicated. Rigid adherence to the so-called aseptic technique—which includes gowning and hand washing on the part of attendants, and physical separation of infected patients from others—is most important.

We cannot hope, in the presence of epidemic influenza, to cope completely with the public health problems that arise, unless it is realized that this disease is perhaps as easily transferred as any other and that the organism suspected of being causative, while not certainly proved specific, possesses many of the characteristics of true specificity.

It is the duty of the hospital superintendent to require the prompt reporting of these cases to the health authorities. To prohibit visiting in the hospital and to provide proper isolation facilities for those cases that have been accepted as patients, are sound and sensible precautions that the hospital should take.

What Information Should a Hospital Give Out About a Patient and Who Should Furnish It?

In most institutions the telephone operator or, in larger hospitals, an information clerk is continually requested to furnish information about the condition of patients. Since these requests are not made in person, the representative of the hospital is unable to interpret whether they are bona fide and whether the purposes for which the information is desired are to the best interests of the patient or his family. The family sometimes even desires that the presence of its relative in the hospital be unknown to the public generally. This is particularly true of persons who are prominent either in public or professional life.

Sometimes diagnoses are requested and these should always be refused when the request is made over the telephone. The results of such laboratory procedures as the Wassermann reaction or certain specific agglutination tests are the property of the hospital and should not be divulged to anyone except on a request or permission from the family. Even at times when internal dissension exists in a family circle, requests from the members of the family should go unrecognized. Grounds for divorce or other such proceedings have sometimes been ascribed to information which has been secured in a not straightforward way.

When accident or criminal cases are admitted to the institution, the police often desire that no information shall be given out by the hospital until the officers of the law have had an opportunity to investigate the circumstances surrounding the case. Such a request from the police department should certainly be honored.

The hospital not infrequently has some difficulty in pacifying overzealous reporters who are bent upon securing in any way possible, information for use in the preparation of news material. It has been the unfortunate experience of some institutions that if information concerning certain intra and extra-hospital events is denied the press, unscrupulous reporters will prepare an article founded upon half or entirely false facts which places the hospital in an embarrassing light. High grade and ethical reporters and papers frown upon such procedures. But at times, the motives of the hospital being misunderstood, the institution is deliberately embarrassed as a sort of punishment for refusing to give out facts.

There can and should be but one person in the institution who is authorized to furnish information concerning such hospital matters. This person should be the superintendent or someone representing him. The dissemination of information relative to the condition of patients is best left to one individual who is skilled in handling these matters. Interns and nurses should be forbidden to communicate to the press information concerning the patients admitted to the hospital or any details of such cases. At times, physicians treating private patients in the hospital are approached for information relative to their condition. This is a difficult angle of the problem to handle, but certainly no information should be given out except that which is approved by the family.

A healthy understanding relationship should be developed between the hospital and the local community papers. The press can do much for the hospital, and the hospital in turn can furnish not a little interesting material that the public will appreciate. The press however must understand that there are certain restrictions upon the type of information that the hospital can and will divulge and should respect this fact. The hospital in appreciation of an understanding attitude on the part of the press, should furnish, freely and accurately, information of the proper sort. The keynote of successful control of this condition is for the dissemination of information to be centralized in one person. Matters of policy and news concerning unusual happenings or of outstanding personages who patronize the hospital should by handled by the superintendent only.

What Rule Should Be Made Governing Smoking by Student Nurses?

Many hospital superintendents and directresses of nurses have been confronted within the last few years with this question. There are those who have persistently frowned upon this practice by student nurses. There are others who formerly were as strongly convinced of its folly but who have allowed their convictions to be so softened that they have either withdrawn their objections or have come to regard the situation as hopeless. To them it represents a decadence in public good manners if not morels

The situation presents a practical problem that must be faced with common sense. There are a number of aspects to this question, of which fire risks in nurses' homes are not the least.

It has been stated that the health of young women who have not as yet reached their majority is not enhanced by excessive smoking. There are still others who consider that graduates in nursing should set a rather high standard of propriety and ethical practice, and who believe that smoking in public is not conducive to the elevation of public opinion concerning the members of their profession.

A physician in attendance upon the members of a hospital training school who were ill was recently surprised and not a little angered to find that his patients, who were suffering with pharyngeal and tonsillar infections, had been smoking in his absence. This practice assumed a distinct medical aspect and the offending nurses were plainly and emphatically told that if they desired his professional care there must not be a repetition of this happening.

It would be a fine thing for the health of the student nurse and for the school generally if a rule forbidding smoking by undergraduates could be enforced. Although in the light of present day opinion this would seem impossible, it is felt that the time has not come when an official recognition of the practice of smoking by student nurses, either in their rooms or in public, should be given by the hospital.

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What Should Be Done When Visiting Chiefs Send Their Private Cases to Other Hospitals?

THE MODERN HOSPITAL has recently editorially stated that the obligations of the visiting staff include not only the attendance, free of charge, upon ward patients, but also the elevation in every way possible of the good name of the hospital as well as its financial income.

It is distinctly and decidedly unfair for a visiting physician to accept the prestige which a staff position must bring without endeavoring to keep the private rooms of that institution full. To be sure, if the hospital upon whose staff he is a member does not furnish adequate private room facilities with efficient nursing and other services, he may be justified in directing wealthy patients toward an institution where de luxe accommodations can be secured. When such is the case, the reasons for so doing should be definitely stated to the hospital management so that an attempt may be made to meet the requirements of the better class of patients.

If there is any stain upon the hospital's reputation from the standpoint of ethics and scientific attainments, such should make impossible his connection with the institution as a visiting physician. Staff members, by virtue of their acceptance of an appointment to the visiting staff of a hospital, morally, if not actually obligate themselves not only to send their ward and semi-private patients to this institution but also to furnish occupants for the higher priced rooms.

The dignified method of meeting this problem would be for a staff physician either to resign his place in an institution he cannot defend or patronize or else to demonstrate his loyalty to the hospital in as practical a way as possible.

How Can the Teaching Value of Postmortem Material Best Be Utilized?

In an institution whose postmortem percentage has been routinely low, marked progress has been made in securing an increased number of examinations on the bodies of patients after death. This hospital finds itself in the possession of pathologic material that it desires to utilize in an educational way.

In the first place, an attempt should be made to have as many interns as possible present at every postmortem examination. The intern in charge of the case prior to death should be obliged always to attend. A register showing the names of those interns who were in attendance at every autopsy, should be kept in the postmortem room. This is necessary, because most state boards of education and licensure require a certificate as to the number of postmortems witnessed by each intern.

A report of the postmortem examination should, of course, find its way to the patient's chart and a copy should be sent to the visiting physician upon whose service the patient was treated. The visiting physician should always be notified when a postmortem examination of one of his former patients is to be held. This may be done by posting in the staff room the postmortems for the day, by calling the physicians concerned on the telephone or by some other way locally practicable. It might not be unwise to keep a record of the staff members who have witnessed autopsies during their term of service.

A clinico-pathological conference is one of the most valuable teaching procedures carried out in the hospital. This is usually held weekly and staff resident physicians are

urged, if not required to attend. The most interesting autopsies of the week are selected for discussion. The clinician describes the ante-mortem aspects of the case, stating his diagnosis and substantiating it with a narration of physical findings and clinical symptoms. A list of the clinical diagnoses may be placed upon the blackboard before the meeting, and in a parallel column may be set down the pathological diagnoses. The pathologist is always present to demonstrate the specimens that have been removed from the case. In the summary that is made by the clinician and the pathologist, an attempt is made to explain errors in diagnosis and to elucidate methods employed in arriving at the correct diagnosis.

The records of the institution may then contain a correct estimate of the skill employed in studying the case, as well as interesting and useful pathological data secured from it. As a result of these conferences, there frequently arises a series of clinico-pathological reports that may do much to elevate the scientific standing of the hospital and to add generally to the knowledge concerning disease.

When Special Surgery Is Required and Staff Surgeons Are Unable to Do It What Is the Alternative?

In an Eastern hospital, a case of brain tumor was admitted to the surgical service and, after having been properly studied, was deemed a suitable case for operation.

Since none of the staff surgeons was qualified by experience or temperament to undertake this type of work, the superintendent was confronted with the alternative of sending this patient to another hospital or of securing the services of a well trained specialist to do this work.

The question is asked whether the hospital should go to the expense of securing proper instruments for this type of operation or whether the patient should be sent to another institution so equipped.

Had this not been an urban institution of such size as to make the repetition of this experience probable, the advice might be given by The MODERN HOSPITAL to send this patient to another institution where the personnel and physical equipment were more adequate. It is true that it has been deemed a wise and economical policy for hospitals to specialize in certain types of work, the equipment for which requires an unusual outlay of money. In this way the repetition of this expenditure in other institutions near by is avoided. Basically, such a scheme is On the other hand, the modern urban hospital should be equipped to care for the usual run of cases. Because of the advances in head surgery, there should be included in this classification operations for the relief of increased intracranial pressure, and occlusion of nerve trunks or roots due to brain tumors and other similar pathological conditions, as well as those for the treatment of intracranial damage due to trauma from without.

In this instance, it would seem wise for the hospital to add to its major staff one or more surgeons qualified to perform neurosurgery and to supply them with the necessary instruments.

It is not fair either to the patient or to the interns for interesting and often emergent surgical conditions to be referred to other hospitals for treatment.

General surgeons should not object to the adoption of this policy. Not only is this type of work a distinct surgical specialty that requires unusual preparation but it also is extremely tedious and physically difficult and demands painstaking and skillfully executed technique.

NEWS OF THE MONTH

New Jersey Hospital Association Holds Fifth Annual Meeting

The New Jersey Hospital Association held its fifth annual convention, November 7 and 8, at the Robert Treat Hotel, Newark, in conjunction with the annual meetings of the New Jersey Tuberculosis League, Inc., and the New Jersey Occupational Therapy Association.

At the opening session, held on Thursday morning, the invocation, given by Rev. John J. Murphy, was followed by the address of welcome, delivered by John F. Murray, Jr., director, department of public works, Newark. A business meeting followed when the minutes were read and various reports were given.

The presidential address by Rev. John Goodridge Martin, superintendent of the hospital of St. Bartholomew, Newark, was followed by a round table discussion on "The Responsibility for Hospital Care of Highway Accidents," presided over by Dr. Emil Frankel. Discussion centered around such questions as: "Should the hospital charge for first aid service? To what extent should the state, county or municipality cooperate? Does the New Jersey law adequately protect the hospital? Are present arrangements with insurance companies satisfactory?"

At the conclusion of the morning session, a luncheon was held in the Robert Treat Hotel on the invitation of the New Jersey Tuberculosis League.

President Martin took the chair at the afternoon session, when the first paper was given by Grace E. Watson, director of nursing education, Jersey City Hospital, Jersey City, who spoke on "The Hospital as a Center for Health Education, With Special Reference to Its Application to Tuberculosis." This paper was discussed by Elizabeth Lewis, superintendent, Englewood Hospital, Englewood. The next speaker was Harriet I. Stone, supervisor of nutrition, Newark public schools, who addressed the delegates on the subject, "How We Help the Child to Help Himself." A paper was next given on "Occupational Therapy and Its Relation to Vocational Education" by Dr. Charles Englander, Essex County Hospital, Cedar Grove. "The Care and Treatment of Nervous and Mental Patients in General Hospitals" was the subject of an address given by Dr. Thomas J. Heldt, of the division of neuropsychiatry, Henry Ford Hospital, Detroit. Dr. Walter C. Klotz, director, Cornell Clinic, New York City, read a paper on "Organization of Hospital and Clinic Service for the Patient of Moderate Means." The Thursday afternoon program closed with the address by Dr. Joseph R. Morrow, superintendent, Bergen County Hospital, Ridgewood, N. J., on "Motion Pictures of National Hospital Day."

On Thursday evening the association held its annual banquet along with the members of the New Jersey Tuberculosis League and the New Jersey Occupational Therapy Association. William L. Ellis, commissioner, department of institutions and agencies, the toastmaster, introduced the following speakers: Dr. Allen Craig, formerly associate director, American College of Surgeons; Dr.

Kendall Emerson, managing director, National Tuberculosis Association; T. B. Kidner, New York, former president, American Occupational Therapy Association and Philip C. Staib, president, board of managers, Bergen County Hospital, Ridgewood.

An interesting feature of the Friday morning session was a round table discussion presided over by Dr. Earl H. Snavely, superintendent, Newark City Hospital. Discussion was invited from the floor on the following topics: compensation case problems; ray clinics; provision for the patient of moderate means; hospital publicity; x-ray charge, and vacation schedules. In addition to this discussion, Eleanor E. Hamilton, R.N., superintendent, Presbyterian Hospital, Newark, read a paper on "Centralized Schools of Nursing" and Marie Louis, R.N., superintendent, Muhlenberg Hospital, Plainfield, N. J., spoke on "The High School Girl as a Nurses' Aid in the Hospital."

The closing session, held on Friday afternoon, was a combined meeting of the New Jersey Hospital Association and the New Jersey Tuberculosis League, Inc. The speakers and their subjects were as follows: Dr. B. S. Pollack, "Ethical Hospital Concepts;" Raphael Kaufmann, "Problems of Hospital Delinquent Collections;" Mary E. Fanning, "Hospital Dietetics;" Leonora E. Rubinow, "Does It Pay Your Hospital to Maintain a Social Service Department?"

Cornerstone Placed for New Hospital Addition

Ceremonies incident to the laying of the cornerstone of the Spencer Memorial Hospital, an addition to the Deaconess Hospital, Great Falls, Mont., were held recently with Gov. John E. Erickson and Bishop Wallace E. Brown officiating.

The Spencer Memorial unit will add 100 beds to the present Deaconess Hospital which was dedicated in 1908, as well as enlarge the medical and surgical quarters. Construction was started last June and it is expected that the building will be equipped and opened by May of 1930.

The Spencer unit joins the old hospital on the east and is designed so that the two buildings will merge in one continuous façade. This involves some remodeling in the present building. The center section of the new portion will be six stories high and a wing of the same height will extend from this section to the alley. The remainder of the building will be four stories high to conform to the size of the present hospital.

The ground floor of the Memorial Hospital will be marked by a memorial lobby dedicated to the late Sam Spencer who gave \$200,000 as a nucleus toward financing the addition. The lobby will be two stories high and will have a coffered, beamed ceiling. This floor also will be occupied by the administration offices, doctors' examining room, main kitchen, dietetic department, a pharmacy,

News of the Month

hydrotherapy department, staff and hospital-board dining rooms, the laundry, waiting rooms and seven private

rooms for patients.

The second floor will be devoted largely to private rooms for patients but also will include a service kitchen, utility room, general nurses' dining room and nonresident nurses' rooms. The maternity department will occupy the third floor with delivery rooms, nurseries and sterilizing room.

Private rooms for surgical cases will occupy the fourth and fifth floors and on the sixth floor will be the surgery, including six operating rooms, splint and plaster

room and x-ray department.

Jefferson Hospital Will Erect **Out-Patient Building**

Plans were announced recently for the construction of a new \$1,000,000 "Curtis Clinic" building for the Jefferson Hospital, Philadelphia, on the site of the old college building. As soon as the college moves into its new building, now near completion, the old college property will be demolished and construction of the new out-patient building will begin.

The clinic will be eight stories high with two base-Two towers will rise above the main structure, which will be joined to the new college building.

The steady and rapid growth of Jefferson, according to officials, shows the necessity for new and more adequately equipped out-patient departments now scattered through several buildings. The new building will contain all of the out-patient departments of the hospital, including the emergency department.

The new structure will mark the fourth building to be added to the Jefferson Medical College and Hospital

in the past five years.

Hospital and Nurses' Home to Be Built at a Cost of \$950,000

A hospital and a nurses' home are to be added to the Lucas County Home, Toledo, Ohio, at an approximate cost of \$950,000, according to a recent announcement. Plans and specifications have been approved by the county building commission. A bond issue for the expenditure was voted last year.

The hospital will be of the Georgian period of architecture and will consist of a ground floor and five stories. The nurses' building is to be of the same type of architecture and will consist of a basement and three

stories. It will accommodate seventy nurses.

The first floor of the hospital will have three operating rooms with an amphitheater adjacent to one of them, with an electrically operated door for clinics and for nurses' and interns' instruction. X-ray departments will also be on this floor, but films will be stored outside the buildings. On this floor will be laboratory and conference rooms, home doctors' and interns' quarters, offices for the superintendent and assistants, the general lobby, nurses' workrooms and surgeons', doctors' and nurses' shower rooms.

The second floor will have four wards extending east, west and south from the main hallway. The third floor will be the same except that it will be used for surgical cases. The obstetric and nursery department will be on the fourth floor. The fifth floor will be used for

All patients will enter the hospital by the ground floor. On this floor there will be an emergency operating room, a splint room and a pharmacy. There will be departments for eye, ear, nose and throat examinations as well as laboratories. The physiotherapy and hydrotherapy departments will be on this floor as will also a morgue and autopsy room.

The main kitchen, the diet kitchen, the main service pantry, a cafeteria and four dining rooms, the baking department, ice machine rooms, the electrical equipment department, a machinery room and general storage quarters will be placed on the ground floor. The ground floor will be but three feet underground and will have an abundance of natural lighting.

Gift Ensures Construction of New Jewish Hospital

The Federation of Jewish Welfare Organizations recently announced an outstanding gift to Jewish philanthropy in Los Angeles when the presentation of \$100,000 by Mr. and Mrs. Ben R. Meyer and Mr. and Mrs. Milton E. Getz was made known.

The money is to be used toward the erection of a new Jewish hospital now under construction. The hospital, toward which the Kaspare Cohn estate, represented by Mr. and Mrs. Meyer and Mr. and Mrs. Getz, had previously contributed \$50,000 to the federation to assist in procuring the building site, has been named the Cedars of Lebanon Hospital.

The new institution will cost, with land, buildings and equipment, approximately \$1,650,000. It will have 250 beds and accommodations for those who can afford the best hospital facilities. In addition it will have fifty-eight free beds for those unable to pay for medical attention, an out-patient department and a school of nursing.

Two Fellowships Established for Orthopedic Research in New York

Dr. J. J. Golub, director, Hospital for Joint Diseases, New York City, one of the fifty-nine member institutions of the United Hospital Fund, announced yesterday that Frederick Brown, the well known philantropist, has given the institution \$100,000 for the establishment of two fellowships in orthopedic research at the hospital, of which he is president. The board of directors has accepted the gift and the fellowships will be known as the Mr. and Mrs. Frederick Brown Fellowships.

The income of the gift, approximately \$4,800 will be awarded annually in sums of \$2,400, each, to two research fellows. The awards will be made by a committee named by Mr. Brown.

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News of the Month

Western Hospital Association Meets at Portland

PORTLAND, Ore., prepared a warm welcome for the delegates and visitors to the third annual meeting of the Western Hospital Association, held in that city, October 24 and 25. The sessions were held in the Multnomah Hotel and interesting program features and social activities marked the event.

Emily L. Loveridge, superintendent, Good Samaritan Hospital, Portland, president of the association, conducted the meeting with skill and there was a representative attendance of hospital officials from the Western states.

The meeting of the Northwest Hospital Association was held at the same time, under the presidency of Carolyn E. Davis, R.N., superintendent, Everett General Hospital, Everett. Wash.

C. J. Cummings Is President-Elect

At a business meeting of the Western Hospital Association the recommendations of the nominating committee were unanimously approved and in accordance therewith the following officers will conduct the affairs of the association during the coming year: president, Dr. Fred C. Bell, superintendent, Vancouver General Hospital, Vancouver, B. C.; president-elect, C. J. Cummings, superintendent, Tacoma General Hospital, Tacoma, Wash.; secretary, Grace Phelps, R.N., superintendent, Doernbecher Memorial Hospital, Portland.

The officers of the Northwestern Hospital Association were unanimously reelected, with the exception of the secretary, Mrs. Cecile Tracy Spry, Tacoma, Wash., being elected to fill that office.

The opening session of the meeting took place at 9:30 a.m., October 24, under the chairmanship of Miss Loveridge. Rev. Harold L. Bowman, First Presbyterian Church, Portland, opened the meeting with prayer, after which C. M. Bigelow, acting mayor of Portland, welcomed the delegates to the city and Mrs. Elizabeth Soule, R.N., director, department of nursing, University of Washington, responded.

The morning session was devoted to a discussion of hospital organization from the standpoints of the superintendent, the medical staff and the school of nursing. A paper by Dr. Howard H. Johnson, medical director, St. Luke's Hospital, San Francisco, was read in his absence by Rev. Axel M. Green, superintendent, Emmanuel Hospital, Portland. It dealt with organization as viewed by the superintendent and pointed out that the successful application of the principles of hospital organization depends largely on the common sense, native executive ability, experience and training of the superintendent.

Dr. Richard B. Dillehunt, dean of the medical school, University of Oregon, who was to speak for the medical staff on this subject was unable to be present and the topic was therefore discussed by Dr. Earl Else, department of surgery, University of Oregon. Sister John Gabriel, R.N., of the Sisters of Charity of Providence Hospitals in the Northwest, covered the subject from the

standpoint of the nursing school. She expressed the belief that a school of nursing should have a separate budget, independent of the hospital and should be under the direction of the department of education.

Dr. M. T. MacEachern, associate director, American College of Surgeons, summed up the discussion, showing the correlation of the various departments and emphasizing the need for a capable superintendent and close supervision of the hospital by its board of directors.

Following the morning session the delegates were the guests of Miss Loveridge at luncheon at the Good Samaritan Hospital.

Miss Davis, vice-president of the Western Hospital Association and president of the Northwestern Hospital Association, took the chair at the afternoon meeting. The first speaker was Dr. Ira Manville, associate professor of physiology, University of Oregon. His topic was "Recent Developments in Nutrition," and he discussed especially the place of iodine in nutrition, the developments of vitamins and iron assimilation in pernicious anemia.

The next topic scheduled for discussion was the development of the U. S. Veterans' Bureau hospitals since the World War. This was covered in a comprehensive manner by Dr. Paul I. Carter, manager, U. S. Veterans' Bureau Hospital, No. 77, Portland.

A paper on "Selling Hospital Service" by E. G. Fulton, business manager, Glendale Sanitarium, Glendale, Calif., aroused much interest and was freely discussed. "Good service solves the problem of advertising, also the vacant bed," said Mr. Fulton. "It also reduces the cost per capita." He emphasized that long after a patient has ceased to think of the scientific appliances and smoothly working machinery of a hospital he will remember with gratitude the kindly human contacts with the members of the hospital staff.

At this session Doctor MacEachern spoke on the need for complete and accurate records; Dr. F. B. Freeland, Portland, on physical therapy, and Mr. Cummings on state rates

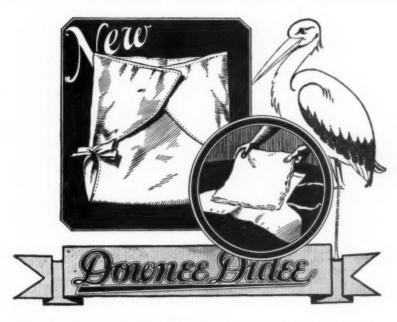
Subject of Cost Again to the Front

The evening gathering was presided over by Mr. Cummings, and the subject of discussion was the high cost of hospital care, from the viewpoint of the patient, the doctor, the nurse and the hospital executive. These angles of the problem were covered respectively by Mrs. Joseph A. Hill, Portland; Dr. Frederick A. Kiehle, University of Oregon; Elnora Thompson, R.N., director of public health nursing, University of Oregon, and G. W. Olson, superintendent, California Lutheran Hospital, Los Angeles. Mr. Olson's paper appears in full on page 69.

Friday morning was devoted to visiting several of the Portland hospitals and at the afternoon meeting a strong program was presented under the chairmanship of Lola M. Armstrong, editor, Western Hospital and Nurses Review.

The New Downee-Didee Is the Modern Sanitary Diaper

Saves Nurses' Time-Reduces Labor Costs-Cuts Laundry Expense



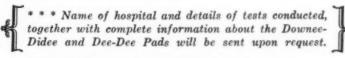
THE Downee-Didee is the most satisfactory diaper for all infants because it is more comfortable for the baby, easier and quicker for the nurse to handle and much more economical than ordinary diapers. It has been thoroughly tested and approved by maternity hospitals and physicians everywhere.

Downee-Didees can be used from birth, as they are made in sizes to fit babies of all ages. Each one replaces a dozen or more ordinary diapers. Dee-Dee Pads, a soft, fluffy, absorbent filler shaped to fit, are placed in the Downee-Didee. They protect the babies' delicate skin and absolutely prevent diaper rash. When soiled or wet, they are removed and easily disposed of as ordinary tissue.

Hospital Tests Prove Saving of 21/2 Times in Laundry

Recent tests in a maternity hospital* show that Downee-Didees not only eliminate the washing of diapers, but protect pinning blankets and bed linens from becoming soiled as well. At a cost of only 19c per baby per day, Downee-Didees save laundering from 35 to 38 pieces for each baby daily in addition to saving much time of nurses and other employees. This small cost is much less than the expense of ordinary diapers, laundry expense and other labor necessary when using the old-fashioned diaper.

The prevention of diaper rash alone warrants the use of Downee-Didees, to say nothing of the convenience in caring for the infants and the comfort of the babies.



Downee-Didee is also made in adult sizes for persons who are incontinent. Information upon request.

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News of the Month

Huge Hospital Under Construction at Cairo, Egypt

One of the largest hospitals in the world is now under construction at Cairo, Egypt, according to announcement made by Dr. Ali Hassan of Cairo, who attended the International Physiological Congress held at Harvard Medical School recently.

The new building will house 1,200 bed patients, the visiting doctor declared, giving a total capacity of 1,800 patients including the present hospital structure. The site of the new building, to be known as the Kasr El Aini Hospital and Medical School, is on Rhoda Island, directly opposite the old building and connected with the mainland by a bridge. The hospital, medical school, nurses' and doctors' quarters and students' clubs will be located in the new group.

In describing the new buildings and telling something of the work of the hospital Dr. Hassan said that for the first time in history women are being admitted to the medical college.

"This year we have six women prepared for entrance and at the end of five years, if they are successful, they may practice medicine in Egypt.

"Our medical school is run on practically the same plan as those in the United States. The students who have matriculated spend six years in the study of medicine. After graduation many of the doctors work in the hospital for a year or more, receiving the same training American doctors receive during their internship.

"Within the next five years the government will erect fifty hospitals in the smaller towns. We also have traveling hospitals that go through the more remote districts, staying from four to six months in each settlement. Practically the entire population of Egypt is in one strip along the banks of the Nile. Railroads run through this strip and the traveling hospitals are sent over the rails.

"The large towns are well supplied with doctors and hospitals, and when our building program is completed, our medical needs should be adequately supplied for a long time."

Work Starts on Great Medical Center in New York

Plans have been filed by New York Hospital and Cornell Medical College for the erection of a huge new medical center in New York City. The new center, to be erected on the east side overlooking the East River, will cover three city blocks and will be one of the most complete institutions for the unified advancement of teaching, research and the care of the sick in the country.

Contracts for the new buildings have been let and ground has been broken but because of the immensity of the project the center will not be completed for at least three years, it is believed. The main hospital building, which will form the hub of the center, will have accommodations for 1,000 patients and the out-patient departments will be equipped to handle that many more ambulatory cases.

The main hospital building will rise twenty-four floors

and will be flanked on the west by buildings which will house the Cornell Medical College and on the east by three special institutes, including a maternity hospital, a children's hospital and a hospital for the treatment of nervous and mental disorders.

Each of these buildings will be linked with the main building. Also connected with the main building will be the nurses' home, employees' quarters, service building, garage and power plant.

The completed group will comprise thirteen buildings, all of the latest fireproof construction. The nurses' home will house 500 student and graduate nurses. One of the structures will provide quarters for 100 resident physicians. Facilities also will be provided for the training of 300 undergraduate medical students and for many advanced students in medicine.

The first eleven floors of the main building will make up a complete general hospital. The twelfth to seventeenth floors will comprise a hospital for private patients. From the eighteenth floor upward will be the living quarters for the physicians and surgeons of the resident staff. In the basement of this central building will be the general and special diet kitchens as well as the rooms for records.

Other buildings will include a maternity hospital, a children's hospital and a hospital for mental cases.

The new center will have combined endowments and other resources amounting to \$100,000,000, it is estimated. The main building is expected to cost \$15,150,000. The General Education Board established by John D. Rockefeller has authorized an appropriation of \$7,500,000, and a bequest of the late Payne Whitney is expected to supply \$15,000,000. In addition the hospital will ask for donations of \$15,000,000 more.

Building Designed Especially for Physicians and Surgeons

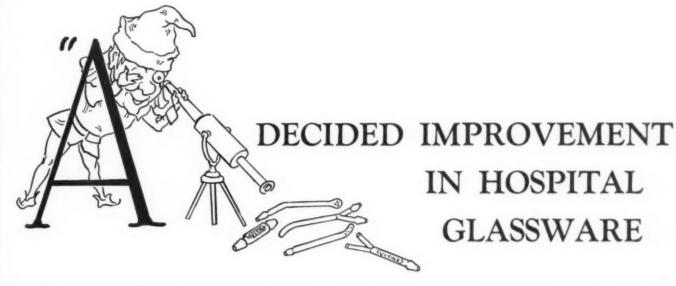
Designed especially for physicians and surgeons, a fourteen-story building is to be erected soon in Cleveland at a cost of \$1,550,000. The structure will be of steel with concrete floors. The exterior will be of Indiana limestone on all four sides.

The building will be known as the Carnegie Medical Building. Commodious quarters for eight shops will be provided on the ground floor and the second floor will offer space for offices of concerns dealing in supplies and equipment for physicians and surgeons, who will be the only tenants of the floors above.

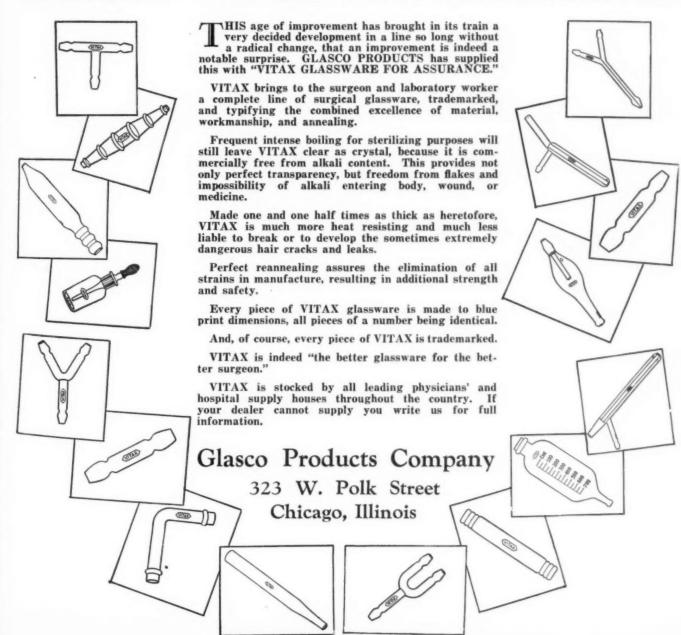
New Community Hospital Serves Kentucky District

Built with funds contributed by residents of the district and the Commonwealth Fund, the \$300,000 community hospital and nurses' home at Glasgow, Ky., was opened recently.

The fifty-two room hospital will serve a district within a radius of forty miles from Glasgow, a territory that has never before had a hospital so easily accessible.



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Personals

EDA KAMRATH, R.N., former anesthetist at St. Andrew's Hospital, Minneapolis, Minn., has been appointed superintendent of the Fairmount Clinic and Hospital, Fairmont, Minn.

CLARA E. GAPINSKI, R.N., former night supervisor, Sartori Memorial Hospital, Cedar Falls, Iowa, has been appointed superintendent of that institution. EMMA JESSEN, R.N., former superintendent, was married recently to Dr. W. L. HEARST of Cedar Falls.

MARGARET J. ROBINSON has been appointed superintendent of the Garfield Park Hospital, Chicago, and assumed her duties November 18. MISS ROBINSON has had wide experience in the hospital field and was for several years superintendent of the Montefiore Hospital, Pittsburgh.

Dr. John N. Alley has been appointed medical officer in charge of the Tuberculosis Hospital for Indians, Tacoma, Washington.

DR. RUSH E. CASTELAW recently resigned his position as superintendent of Wesley Hospital, Kansas City, Mo., to become superintendent of Decatur and Macon County Hospital, Decatur, Ill.

SARAH A. RUDDY, R.N., formerly superintendent, San Clemente Hospital, San Clemente, Calif., has been appointed superintendent of the Long Beach Community Hospital, Long Beach, Calif.

MARGARET HALES ROSE, R.N., formerly in charge of the educational department of the Decatur and Macon County Hospital, Decatur, Ill., has been appointed superintendent of the Washington County Hospital, Washington, Iowa.

LUCY ANN MARSHALL has become superintendent of the Seaside Hospital of Long Beach, Calif. She was formerly superintendent of the New York Hospital for Women and Children.

ESTHER H. ISKER has become superintendent of the Itasca County Hospital, Grand Rapids, Mich. She was formerly instructor of nurses at the Phoebe Putney Memorial Hospital, Albany, Ga.

MARION COPE, R.N., formerly superintendent of the Mattie Williams Hospital, Richlands, Va., has been appointed superintendent of the Masonic Hospital, Cushing, Okla.

J. M. Scott is superintendent of Grace Hospital, Edmonton, Alberta, Canada. Prior to accepting this superintendency she was affiliated with the Booth Memorial Hospital, Covington, Ky.

Dr. John G. Lamont has resigned as superintendent of the North Dakota State Tuberculosis Sanatorium, San Haven, N. D., to become associate medical director of the St. Louis County Sanatorium, Duluth, Minn. He is succeeded at the state institution by Dr. Charles MacLachlan of New Rockford, who also succeeded him as secretary of the North Dakota State Medical Association,

MARGARET M. STODDARD, R.N., has been named superintendent of the Mary Frances Skiff Memorial Hospital, Newton, Iowa. MISS STODDARD was superintendent of Henry County Soldiers and Sailors Memorial Hospital, Mount Pleasant, Iowa, prior to her present connection.

DIXIE D. DAVIS, R.N., has been appointed superintendent of Cedar Hill Hospital, Dayton, Tenn.

SISTER M. VICTORINE has been named superintendent of St. Joseph's Hospital, Alton, Ill., succeeding SISTER AGATHA who died in September.

MISS F. P. ALLEN is the new superintendent of the King's Daughters' Hospital, Portsmouth, Va., succeeding Florence A. Bishop.

SISTER M. CONSTANCE who has been connected with Borges Hospital, Kalamazoo, Mich., has been placed in charge of the new Mercy Hospital that is being built in Monroe, Mich.

SISTER FLAMINA is now superintendent of Georgetown University Hospital, Washington, D. C. She succeeds Sister Donata.

MRS. VERA BONINE has become superintendent of the Los Banos Hospital, Los Banos, Calif.

THERESA YOUNGER is the new superintendent of the Scottish Rite Hospital for Crippled Children, Decatur, Ga.

DR. DEWALT PAYNE, former health officer of Douglas County, Ore., has been appointed superintendent of the Eastern Oregon Tuberculosis Hospital, The Dalles. DR. HERBERT K. KENT of Minneapolis succeeds Doctor Payne.

JAMES McDonell has become superintendent of the County Detention Hospital, Butte, Mont.

LOURDES GERRITY has accepted the position of superintendent of Fitch Sanitarium, New York City.

ADA MILLER has been made superintendent of the Bellaire City Hospital, Bellaire, Mich.

MARY E. SMITH is now superintendent of Dover General Hospital, Dover, N. J.

AMELIA SAGEN is the new superintendent of Ortonville Evangelical Hospital, Ortonville, Minn. REBECCA PETERSON, the former superintendent, is taking post graduate work in Chicago.

EDNA D. PRICE, R.N., recently became superintendent of Emerson Hospital, Concord, Mass. She was formerly connected with Faulkner Hospital, Boston, as obstetrical supervisor.

RUTH ELDRED, R.N., is now superintendent of St. John's Hospital, Fort Smith, Ark.

DR. R. M. RICHEY has been appointed medical superintendent of the Mendocino State Hospital, Talmadge, Calif. Doctor RICHEY leaves the superintendency of Pacific Colony Hospital, Spadra, Calif., to take up his new position.

KATE CROWE has been named superintendent of Emergency Hospital, Crestline, Ohio.

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News of the Month

Florence Nightingale Medal Awarded to Canadian Nurse

Anne Hartley, R.R.C., matron-in-chief of the hospitals of the Department of Pensions and National Health, Canada, has been awarded the Florence Nightingale medal, according to an article appearing in a recent issue of *The Canadian Nurse*. This medal is awarded biennially by the International Committee of Red Cross to a few nurses in different countries who have given conspicuous service in time of war or public calamity.

Miss Hartley is a graduate of the Toronto General Hospital and served overseas in France, Salonika and England from 1915 to 1919. She received the Royal Red Cross in 1916, and bar to this decoration in 1919. Since the war she has been matron of various government hospitals for returned soldiers and in January, 1929, was appointed to her present position.

Only one other Canadian nurse, Miss MacDonald, former matron-in-chief of the C. A. M. C. Nursing Forces, has received the Florence Nightingale medal.

Land and Money Donated for Tuberculosis Hospital

Mr. and Mrs. David Lynn Ross, Lafayette, Ind., have donated \$140,000 and a sixty-acre tract of land for the site and construction of a tuberculosis hospital for Tippecanoe County, it was announced recently.

The sanitarium will be known as the William Ross Sanitarium in memory of William Ross.

A wooded knoll located on the Indianapolis-Lafayette road four miles southeast of Lafayette is the site for the new structure, which will be of early American colonial design. It will be three stories high, fireproof and sound-proof throughout and will accommodate thirty-five patients.

Hudson River Valley Hospital Superintendents Meet

The hospitals of the Hudson River Valley held a luncheon meeting on Thursday, November 14, at the Vassar Alumnae House, Poughkeepsie, N. Y. The meeting was sponsored by the Westchester County and the Capitol (Albany and vicinity) Associations and attendance included superintendents from New Rochelle, Mount Vernon, Yonkers, White Plains, Valhalla, Peekskill, Middletown, Newburgh, Kingston, Poughkeepsie, Troy, Albany, Schenectady, Glens Falls and Saratoga Springs.

Fifty persons were present and it is believed that one or more additional county or regional hospital associations will be organized, as a result of this meeting.

Dr. C. W. Munger, president of the New York State Hospital Association, presided. Short talks were given by Clarence Ford, New York State Department of Social Welfare, Dr. Richard Slee, New York State Department of Health and J. J. Weber, superintendent, Vassar Brothers Hospital, Poughkeepsie.

Two very interesting papers were given by F. J.

Schlink, secretary of the American Standards Association, on "How to Increase the Buying Value of the Hospital Dollar," and by Dr. E. H. Lewinski-Corwin of the United Hospital Fund, New York, on "The Social Significance of Hospital Costs."

Beautiful Medical Structure Opened at Muncie

Ball Memorial Hospital, a gift of the Ball brothers to the citizens of Muncie, Ind., and built at a cost of \$1,-000,000 exclusive of furnishings, was opened to the public recently.

The hospital is declared to be one of the most beautiful and finely equipped in Indiana and has beds for 150 patients. The building is three stories high, and is constructed of varicolored matt-faced brick, trimmed with limestone. Imposing bays at the sides of the hospital are furnished as solariums. There are fourteen large sun parlors.

Instead of the conventional all white hospital furnishings the building is decorated in soft, harmonious colorings.

There are five operating rooms, an x-ray room and other special departments each containing the most modern equipment. A feature of the hospital is a forced air system of ventilation by means of which air in every room in the building will be changed from four to six times daily. The system is in three units, one of which supplies fresh air to the operating rooms, another to the hospital and the third to the kitchens.

An elaborate silent signal system has been installed, including the nurses' signal system, the doctors' in and out register, the doctors' paging system, the house telephone system and the fire alarm.

A new nurses' home also is under construction to accommodate 100 student nurses. The ground floor will include lecture and classrooms, laboratories for dietetics and nursing. The first floor will be occupied with reception rooms, offices, suites for the administrator and director and several single apartments for the department heads. The second floor will be given over entirely to single and double bedrooms for the nurses. Each floor will be equipped with a kitchenette and small laundry.

Build Hospital for Treatment of Nervous Disorders

Construction of the Emma Pendleton Bradley Home at East Providence, R. I., a hospital for the study and treatment of obscure nervous disorders, is now under way.

The hospital is made possible through provision made by the late Mr. and Mrs. George Lothrop Bradley and is built in memory of their daughter, who died from a nervous disease.

A thirty-five acre site has been acquired for the hospital. About ten acres surrounding the main building will be landscaped and the remainder will be left in its natural state.

Children will be given preference to adults as patients in accordance with the desires of Mr. and Mrs. Bradley.

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News of the Month

Dr. Fishbein Speaks at Nursing Meeting in Chicago

The Central Council for Nursing Education, Chicago, held a luncheon meeting in the red lacquer room of the Palmer House, November 13, when Mrs. James A. Patten was chairman of the committee in charge of the luncheon.

There was a crowded and enthusiastic attendance, presided over by Mrs. Andrew McLeish, chairman of the council. Prominent Chicago hospitals were well represented, there being noted among those present such leading administrators as Asa S. Bacon, Presbyterian Hospital, Dr. Irving S. Cutter, Passavant Hospital, E. S. Gilmore, Wesley Memorial Hospital, Rev. J. H. Bauernfeind, Evangelical Deaconess Hospital, and others. Members of hospital boards of directors, of women's auxiliary boards, of medical and nursing staffs, of alumnae associations of schools of nursing, were there in large numbers and many well known Chicago women who are active in furthering the objects of the council, notably Mrs. Ernest E. Irons, Mrs. Joseph M. Cudahy, Mrs. Gustavus F. Swift and Mrs. Theodore Tiekin.

Mass Methods Assailed

Dr. Morris Fishbein, editor of the Journal of the American Medical Association, Chicago, was the speaker on this occasion and was presented by Mrs. McLeish.

Doctor Fishbein's subject was "The Cost of Medical Care." He handled it with notable skill, presenting his points in clear and forceful fashion, so that his hearers never lost the thread of his reasoning and followed his remarks with close attention and marked interest. The problem of the cost of medical care cannot, he said, be separated from the economic situation as it exists in the United States to-day. Americans have drifted away from simple living and constantly strive to introduce more luxuries into their everyday life, whether they can afford them or not, Doctor Fishbein believes. Similarly, when they are sick they demand luxurious hospital care whether they can pay for it or not. One step in meeting the problem, then, is to educate them as to what is proper medical care.

That medical education and hospital care are inherently costly must be accepted as true, for all statistics point to this conclusion. Therefore the cost of medical and hospital service cannot be appreciably lowered, Doctor Fishbein holds, and private philanthropy and endowment must play a large part in the solution of this problem. Also, possibly, he believes, government control may be needed to oblige men to accept the fact that at some time they will need medical service and must make financial provision for meeting the cost of that service. These are considerations that point a way out of the impasse.

In conclusion Doctor Fishbein denounced the trend toward mass methods of handling human beings for the diagnosis and treatment of disease. Mass machine methods and mass organization, however successfully they may have served in industry, do not apply to medicine in any great degree, therefore medicine has resisted and should resist them, for the best interests of humanity, he said.

Course in Hospital Management Opens in New York

A course in hospital management was recently inaugurated at the Fordham University School of Sociology and Social Service in the Woolworth Building, New York City.

Dr. Shirley W. Wynne, commissioner of public health, Dr. Joseph Turner, director, Mount Sinai Hospital, New York City, and Dr. John E. Daugherty, executive director, Jewish Hospital, Brooklyn, together with Rev. Mathew L. Fortier, S.J., Ph.D., dean of the school, worked out a progressive and integrated plan, covering both the content of the course and its method and technique of presentation.

One of the three regular lecturers, Doctor Wynne made himself responsible for the general topic of health and public relations. Doctor Turner took over his own specialty, organization and clinical functions, while Doctor Daugherty assumed the teaching of the economics of hospital management.

Supplementing this program, specialists in their fields are to give lectures on subjects touching the wider reaches of hospital administration. Dr. Michael M. Davis, director of medical service, Julius Rosenwald Fund, Chicago, Dr. Malcolm T. MacEachern, associate director, American College of Surgeons, Chicago, and Clarence Ford, New York City, will lecture. Legal relations will be treated by Justice Callaghan, Brooklyn; Dr. S. S. Goldwater, New York City, will discuss hospital construction, while Alice G. Moriarty and Elizabeth A. Greener will deal respectively with medical social service and nurses' training schools.

The course is planned to extend over a period of two years, the lectures being given each Friday afternoon from two to four o'clock.

The course opened with an enrollment of seventy students and each succeeding week has seen an increase in the number of students registered and growing interest in the work.

Max Mason Elected Head of Rockefeller Foundation

Dr. Max Mason, president of the University of Chicago for three years, was elected president of the Rockefeller Foundation at a meeting of its trustees held November 13. He will succeed Dr. George E. Vincent who retires on January 1, 1930.

Doctor Vincent has been president of the foundation since May 15, 1917, and has reached the specified age of retirement.

Doctor Mason was graduated from the University of Wisconsin in 1898. He received a doctor of philosophy degree from the University of Göttingen in 1903 and later was instructor at Massachusetts Institute of Technology. He was assistant professor of mathematics at Yale university from 1904 to 1908 and was professor of mathematical physics in the University of Wisconsin from 1908 to 1925.

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EVEN THE STOCK MARKET CRASH

DOESN'T AFFECT IN THE SLIGHTEST
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WARD, WELLS and DRESHMAN CAMPAIGN

ST. JOSEPH'S HOSPITAL at Parkersburg, W. Va., needed \$300,000 for a new building. Ward, Wells and Dreshman, having directed similar campaigns near there (one at Marietta, two at Wheeling, two at Steubenville, two at Washington, Pa., and elsewhere) were invited to take charge.

The day before the campaign opened the Stock Market crashed and made most everybody in Parkersburg and vicinity feel much poorer than ever before.

Everybody feared the campaign was dead, but the Campaign Committee met and were induced to fight it out.

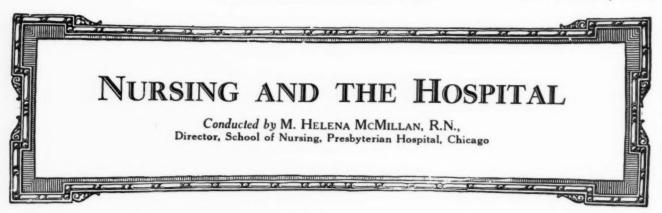
Exactly one week from the hour of this meeting the campaign teams and committee reports pushed the total "over the top."

Parkersburg's greatest previous campaign accomplishment had been about \$80,000. Of course everybody predicted defeat for the effort to raise \$300,000 for St. Joseph's.

The final returns totalled \$332,800.00 with more to come.

Don't fret about the stock market—get the right firm to direct your campaign.

WARD, WELLS AND DRESHMAN
475 Fifth Avenue
New York City



The Problem of Placing the Private Duty Nurse*

By LUCY VAN FRANK

Registrar, Chicago Nurses' Club and Registry

THE modern private duty nurse differs from the private duty nurse of a few years ago. When the private duty nurse of yesterday went into a home to care for the sick, she became temporarily a member of the family and adjusted herself as best she could to whatever conditions she found there. The private duty nurse of to-day has become the "special nurse" in the hospital and seeks a twelve-hour service or less. She has more time for rest and relaxation and a better opportunity to lead a normal life.

In her innate desire for a comfortable home life, she looks forward to something better than the hall bedroom. As an example of this, one day recently, within a period of thirty minutes the Chicago Nurses' Registry received seven changes of address. Two of these nurses had moved two weeks before and one had moved three times within a week. Unattractive rooms in private homes and indifferently handled telephone service cause many nurses to take small apartments which they cannot afford or to go into larger apartments with groups of nurses.

Securing the Nurse's Cooperation

That the Chicago Nurses' Registry may secure the cooperation of the nurse at the beginning the nurse, on her initial visit to the registry, is greeted and handed a copy of the registry rules. This she is requested to read before filling in the application blank. At this time she is asked to plan for whatever free time she wants daily while she is waiting for a call. This obviates the necessity of telephoning and does away with one hindrance to registry service to hospitals and to private duty patients. Those nurses who register for night duty are allowed freedom until five o'clock each day if they wish. The majority of the night nurses are called after that hour, an outgoing telephone being used for this purpose. This arrangement is appreciated by nurses who used to sit anxiously waiting for a call. The new applicant is taken into the office where calls are received and filled and the system of handling the registry business is explained to her. This has been a great help both to the

nurse and to the registry. When the nurse knows exactly what the registry procedure is, her confidence is gained.

The greatest difficulty at the registry during dull periods arises from the desire of nurses to know their position on the list. With calls being received on four incoming lines, all of them often busy at the same time, it is necessary to expedite each call as quickly as possible. The register containing the available nurses is in constant use. Only one person can work well with it at one time and she is worked to the limit much of her time on duty. It is here that the cooperation of the nurse is needed, for if she telephones unnecessarily she is hindering the more important service of receiving calls for nurses.

A Day at the Registry

When Julia Wilkinson, who was appointed field representative by the American Nurses Association to study registries, visited the Chicago office in June, she said, "I do not want to take your time to go into a lot of details, but I would like to sit down in the registry office and listen in." And for three days she listened in. Perhaps others would like to listen in and learn what can happen within a ten minute period. Let us say it is 9:30 in the morning on a Friday in September. A hospital is asking for a list of its nurses. It is requested to hold the wire while another call is answered. It is a nurse who is asking how many nurses are on for days on her hospital list. Thirty-two are counted. Then she wants to know how many for nights and is told about eighteen. She replies, "Well, all right, put me on for days." The long list for the hospital is started, but two more calls interrupt. The others hold the wire while the hospital list is completed. This hospital files a call for one day nurse and four night nurses. Then the telephone numbers of two nurses not on call are requested. A nurse inquires her position on the list. She is told she is No. 20. replies, "How is that? I was No. 16 yesterday." is reminded that, in accordance with rules, nurses who report in after short cases are returned to their original position on the list. Another one telephones in for relief

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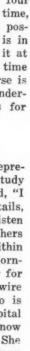
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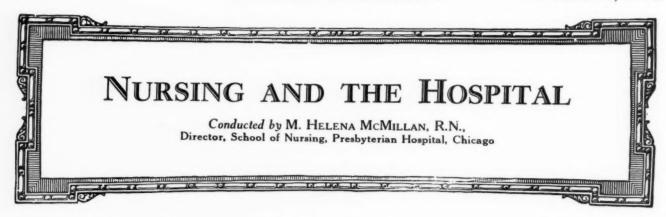
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AFTER the Civil War, men of vision saw that unrestricted and unified growth of the United States depended upon linking the East and West coasts with quick, dependable transportation. So the existing Central Pacific Railway was pushed eastward from California; the Union Pacific built westward from Omaha. They were joined at Promontory Point, Utah, May 10, 1869, where a gold spike was driven to celebrate this event of national significance. Sales Offices and Warehouses "See First"

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and wants a nurse she knows. She waits while another person is asked to hold the wire and another, a physician, asks for a nurse for twenty-four-hour duty in a home. All wires are cleared.

Another nurse registers, saying, "Where shall I be on the list?" When told, she says, "Register me off for the day." Someone is asking for the list and wants the telephone numbers of eight of the registrants. Another nurse registers in. We notify the hospital who requested a certain day nurse that she is not available. Another is named and called. Now a woman's voice is inquiring for a Miss Mouse from a Fairchild Hospital somewhere. When she is told that no such person is registered, she replies, "Oh, yes, she is. I was on a case with her two months ago." The address of the patient and date of call are secured and verified. Miss Mouse, it seems, is Miss Muus and she was from Fairview, not Fairchild Hospital.

There are those who may well ask, "Why do you not correct some of the bad habits of your nurses?" That is what the registry is trying to do. It is trying to educate the nurse to a better understanding of her relationships. But there is yet much to be done. Some of the older nurses understand, but new nurses keep coming and the registry must do the best it can with the material it has.

No Room for the Dull Nurse

The long wait in dull seasons brings many nurses to the registry seeking other work. They know not what. General duty is scorned by many because they consider the grind imposed by many hospitals as a step backward. They say that not only supervisors but even student nurses show a contempt for their services. This may be the fault of the individual but, nevertheless, it is worth considering. Until general duty nurses are given recognition commensurate with this important service, desirable nurses cannot be attracted to this field. Many do accept general duty temporarily and as soon as private duty improves they return to it. Many nurses, chafing under the long hours, are seeking office and industrial work. The smallest demand, however, is in these fields.

The most unpopular cases are contagious, country and holiday cases. Night calls and home calls are not welcomed, especially night duty in homes in the winter. The reason for the latter is that nurses are often uncomfortably cold and many have lost time through illness brought on by exposure.

Although the registry adheres to a strict rule of registering and assigning nurses in order of precedence, it is observed that more and more are the best qualified nurses sought and requested. Nurses should know this and should endeavor to improve themselves, not only in quality of service and technical skill but also in human understanding and cheerful cooperation. There is no room for the dull nurse. Hence, when some nurses are passed by and others preferred the registry must explain to the nurses who were passed by that the other nurses were personally requested. There is much open resentment shown on this account, but the unwanted nurse should take stock of herself and try to make her service more desirable.

A lack of interest is often shown by many nurses in the matter of diet for the home patient. As soon as a nurse is told that she will be required to prepare the meals, there is an inclination to refuse. From the registry point of view all nurses should be equipped and willing to give this service when necessary, since diet is an important factor in bringing about the quick recovery of the patient. Also, when there are two nurses on a case, it often happens that there is no provision made for the night nurse's meal. It is a courtesy the day nurse should extend to her sister nurse to see that this matter is attended to.

Nurses Must Keep Up to Date

The private duty nurse still has the greatest stronghold in the nursing profession since it is she who comes in closest contact with the public at large by giving the actual bedside care to the sick. For this reason she can never afford to stop studying the latest nursing procedures, learning the newest drugs on the market and informing herself concerning new diets and new public health movements. She needs to take occasional postgraduate courses, to do relief work in institutions and to attend clinics when possible. This may be done in dull seasons when she is waiting for calls. The grateful patient will spare no pains in circulating the good reputation of the nurse who has been kind and faithful to him during an illness, and he will often judge all nurses by the impression one has made upon him. He will even include the institution in his good will. Thus it may be seen how much depends upon the impression the private duty nurse makes on the patient, the doctor and the public. She often holds at stake the reputation of the entire profession as well as that of the institution in which she may be serving.

In like manner, the nurse is dependent upon the institution either directly or indirectly for her calls. Therefore, she owes to the institution that employs her obedience to its rules and loyalty to her patient, to the doctor and to her sister nurses. One of the greatest complaints against private duty nurses is their spirit of criticism of physicians and of the rules and the management of hospitals other than their own. How frequently does one hear such expressions as, "We never do thus and so in our hospital." "Dr. So and So always gives such and such in these cases." These little criticisms are made thoughtlessly but much harm frequently results. Such nurses do not stop to consider the differences in type, construction and means of maintenance that keep many hospitals from having the equipment that is found in large city hospitals.

How the Hospital May Help

Another point to be considered is the nurse herself and the influence she has on the student nurse with whom she is closely allied. What must be the student's impression when she sees how little regard the special nurse has for obedience to rules? A special nurse often complains about the lack of facilities that some hospitals have for graduates. She may say the hospital has no place but a lavatory or her patient's room in which she may dress and that she has no locker for her clothes. A locker room and dressing room where special nurses may relax when their patients have visitors or when they have a free time might obviate the loitering in corridors and the bad example shown to the student group. Private duty nurses also should be invited to attend hospital clinics and lectures when they are at liberty. There are many nurses who would welcome such an opportunity and the benefits they derive from such lectures would reflect in their work.

What does the institution owe to the private duty nurse? To what extent may it be blamed for her shortcomings? How may they be remedied? When the private duty nurse enters the hospital, especially if she 1 a ade rse

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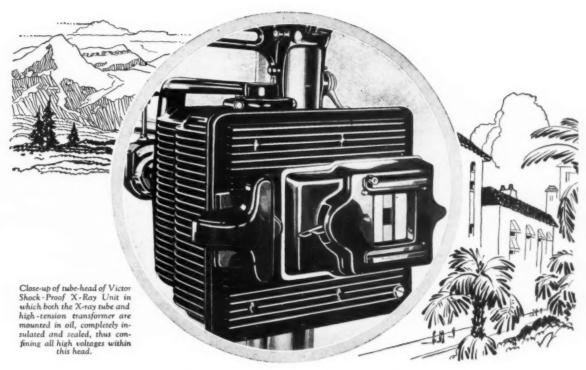
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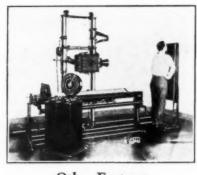
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'HE method used to make the Victor Shock-Proof X-Ray Unit 100% electrically safe, happily has made inherent another valuable feature, namely, imperviousness to all atmospheric conditions. Extreme humidity, which is probably the most troublesome atmospheric variation in operating other types of X-ray equipment, cannot affect the Victor Shock-Proof because all high voltage parts are immersed in oil. Likewise, altitude cannot affect its operation. The output will be the same in mountain regions as at sea level.

This uniformity of output is an advantage second only in importance to the SAFETY of this unit. Because both X-ray tube and high tension transformer are sealed in oil in one container, all danger of shock is absolutely eliminated. There is no high tension current except inside the tube-head and complete insulation renders it harmless. You can touch any part of this Victor apparatus with complete safety

In the first few months of production, shipments of the Victor Shock-Proof X-Ray Unit have been made to ten foreign countries. In this country and abroad, this unit is hailed as the most important development in roentgenology since the Coolidge tube itself.

We have published a complete description of this outfit in an illustrated booklet which we will gladly mail upon request.

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is not familiar with the institution, she should be taken first to the nurses' dressing room and then to her patient. She should be shown the patient's chart and the doctor's orders. The location of the utility room and the diet kitchen should be pointed out. She should be informed concerning the time meals are served, and a nurse should direct her to the dining room and relieve her for meals if the patient requires it.

An Unfortunate Incident

Recently a nurse reported that she had a very ill patient on night duty who required continuous attention. She had never nursed in that particular institution before and knew nothing of the rules. She was given no information as to where or when the midnight meal would be served. When she stepped out in the hall to see what she could find out, the nurse in charge told her she was too late and that she did not relieve special nurses for supper. The special nurses, it seemed, had to relieve each other. How heartsick this tired, hungry nurse must have felt to be treated thus by a student nurse. One fears for the patients who are to fall to the mercies of so heartless and indifferent an individual.

This incident, however, was not all. In the morning before going off duty, this same special nurse stepped into the training school office to find out if the information given by the student nurse was correct. She was told that she was impudent when she remarked that it did seem as if the hospital should make some provision to relieve special nurses and not make them dependent on each other especially when they must remain at their patients' bedsides. This nurse reported her experience to the registry and said she would not care to return to the institution again. Later the hospital reported that the nurse had been rude to students and to the night supervisor, that she was critical of the hospital in general and that it did not want her again. It is to be hoped that the time is not far off when it will be possible to follow up such incidents from the headquarters office and, by friendly interest and cooperation, to correct such conditions. In fairness, however, to the large majority of private duty nurses, it must be said that they are noncomplaining, cooperative and courageous.

The pressing need in some of the smaller training schools for students to carry on the work, has forced many a superintendent to accept a candidate whom her better judgment warns her against. As time goes on she finds there are more rough edges than can be smoothed, but the nurse has already served months. Finally the nurse is graduated but she has neither the ability nor the personality to become a success. Not being favored with many calls from her own hospital, she seeks a new field through registries. She is recommended by her superintendent and accepted, and because of the lack of any follow-up work it may be some time before the registry finds out that her nursing is of poor quality. When the registry has sufficient proof of her failure she is eliminated. She weeps over her failure. How much better it would have been to let her do her weeping before she had sacrificed three years in futile training.

Home Calls Not to Be Scorned

Let us survey then with sympathetic understanding the various problems of the private duty nurse who must arise in the early morning and, as some have remarked, "go forth on the street where only the milkman is in evidence" and board a street car with the laboring man. This is followed by long hours of duty interspersed with longer periods of waiting. Her subsequent struggle to

maintain a decent standard of living must be thought of. She meets with lack of cooperation among her associates. All the time her own obligations are pressing in upon her, and she finds it almost impossible to lay by for that "rainy day" ahead.

Yet, in spite of all this, every official registry is handicapped in its service because private duty nurses refuse to take home cases and openly say they would rather wait until their turn comes and go to their own hospital. For this reason registries depend largely for the care of home cases on nurses with no school connection in the city. Something drastic may have to be done to correct this situation. Nurses must realize that when physicians have a patient in the home, a nurse who understands his methods is just as essential to him there as she is in the hospital. This refusal of nurses to respond is doubtless the reason for much of the bitterness exhibited by the medical profession against nurses.

Many doctors have made the statement that they will not employ nurses on their hospital cases if they refuse their home calls. The registry cannot always keep this matter under cover for the doctors demand and the registry must respond. Necessity drives many nurses to do what they do not want to do and many times the doing of it brings better light and understanding. A cheerful response to any call should be every nurse's motto. But how can this spirit prevail unless we have understanding, unselfish women in our training schools. With every nurse a teacher of health, we may even look forward to the time when, instead of the long hours spent in nursing the sick, we shall have not more than an eight-hour day and we shall devote that to teaching a world how to keep well.

A. N. A. Publishes Historical Sketch

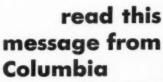
The American Nurses Association has recently issued a historical sketch of its birth and growth. It has been prepared by Virginia McCormick, publicity secretary of the association, who points out that an effort has been made to emphasize only the outstanding events in the development of the organization and to place the official association of nurses in its relation to the growth of the profession in the United States.

Starting with the establishment of the Bellevue Alumnae Association in 1889 the sketch carefully traces the phenomenal development of the nursing profession, the development of the National Society of Nurse Educators in 1893, the birth of its daughter, the Association of the Nurses of America, in 1897, and the birth of its grand-daughter, the National Organization for Public Health Nursing in 1912. The present many activities of the association are described, including the American Journal of Nursing headquarters and various funds and affiliations, while a graphic picture is presented of the connection of the individual nurse, through her alumnae, district, state and national organizations, with the International Council of Nurses which brings her into contact with the nurses of the world.

"The Historical Sketch of the American Nurses Association" ends with the challenge of new work for the association, a work it can accomplish "so long as its foundations are hewn deep into the rock upon which it has been built of self-giving and intelligent service."

The sketch should be of especial use to teachers of history of nursing and should be stimulating to the seasoned graduate and young student alike. The edition is worth reading and recommending to others.





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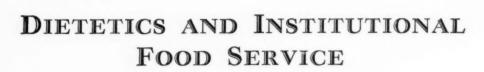
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Carrying Holiday Cheer to the Sick on the Christmas Tray

By ELSBETH J. HENNECKE

Dietitian, Presbyterian Hospital, Chicago

HRISTMAS day! Thoughts of home, with all the family happy together!

Those who have to spend Christmas in a hospital may look upon it as a great misfortune. Although it is disappointing not to be able to participate in the usual Christmas activities of the family, next to home the hospital can be made a most pleasant place in which to spend Christmas. For where, beside home, are more care and thought given to make a person comfortable and happy than in a hospital? A happy Christmas for the hospital's patients is the plan uppermost in the minds of all hospital attendants, and it is about this plan that the hospital arranges its daily schedule.

How Christmas Trays Create Cheer

It is on Christmas day that the dietitian comes to the foreground. The patients' nursing care on Christmas day is much the same as on other days. The medical and surgical attendants make rounds and add their word of cheer. When it comes to dinner, however, the day can be made perfect or it can be spoiled completely. Here the dietitian is responsible. On all days the trays

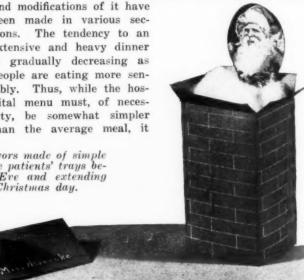
that go to each room can be the source of great physical and mental comfort to the patient or, on the other hand, they can cause especial unhappiness and discomfort. If, then, the dietitian is to help create an atmosphere of

happiness for the patient on Christmas day, she must make his tray a palatable and attractive one, so that when he has finished his meal, he may feel that he has not been denied the joys of Christmas entirely.

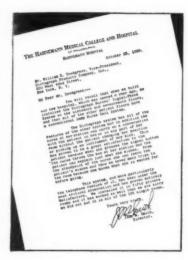
In planning the Christmas day meals, there is much to be taken into consideration. Fortunately, it is the one day when the purse strings may be loosened, and the fancies of the dietitian may wander about a bit more than usual. Anything added to the usual is a treat, so no matter what the daily tray has been, additions to it are acceptable. The types of trays to be served will determine largely the planning of the menu. When the doctors will generously allow a full tray for their special diet patients on Christmas day, the problem is comparatively easy. When it is necessary to adhere to the special diet, the ingenuity must be taxed. Let us consider the general tray first, as it affects the larger number of patients.

Certain foods are characteristic of Christmas dinners. Each country has had its own typical menu which has been brought to this country and made a part of ours,

and modifications of it have been made in various sections. The tendency to an extensive and heavy dinner is gradually decreasing as people are eating more sensibly. Thus, while the hospital menu must, of necessity, be somewhat simpler than the average meal, it



Appropriate Christmas favors made of simple materials are placed on the patients' trays be-ginning with Christmas Eve and extending through supper on Christmas day.



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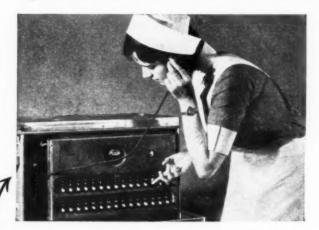
is proving its superiority in the country's leading hospitals



THIS system . . . has been under the most critical observation and has proven entirely satisfactory. We installed it in fifty private rooms and it has worked so well that we are sorry we did not put it in all of the 185 single rooms", writes Mr. J. M. Smith, Director of The Hahnemann Hospital of Philadelphia . . . "After a long trial we have found it most satisfactory", is the verdict of St. Francis Hospital in Hartford . . . Wherever the Dictograph Nurses' Signal-Phone System has been installed it has been a notable factor in eliminating wasted time in nursing procedure and in promoting better service to patients.

THE new Nurses' Signal-Phone provides, in addition to the customary features of door lamps, corridor lamps and signals at the nurses' station, a unique telephonic contact between patient and nurse made possible by the super-sensitive Dictograph microphone and "soft speaker."

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on the Nurses' Signal-Phone tells which patient is calling. In addition an audible signal is provided in the form of a soft-toned buzzer. The nurse lifts the receiver on her Signal-Phone, raises the key under the signal, and speaks to the patient.

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were at the bedside. Conversational contact with the Signal-Phone is as effortless as tho nurse and patient were together in the room.

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DICTOGRAPH



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can still carry out much the same plan. The following day's menu is, perhaps, fairly typical of a hospital menu on Christmas day.

MENU

Breakfast

Grapefruit Stewed Prunes Rice Crispies Eggs

Oatmeal Bacon

Toast

Coffee

Dinner

Cream of Asparagus Soup Roast Turkey

Mashed Potatoes Chestnut Dressing and Gravy Cranberry Jelly

Creamed Carrots Buttered Peas

Purée of Peas

Candle Salad

Celery and Olives

Nuts and Raisins

Hard Candies

Vanilla Ice Cream With Cherry Sauce

Beverage

Supper

Oyster Stew With Salted Wafers

Baked Squash Purée of Squash

Mistletoe Salad Fresh Fruit

French Dressing Fruit Cake

Chocolate Bavarian Cream

Beverage

This menu is suitable not only to the patient on a general tray, but it can also be adapted readily to various diets, thereby eliminating the extra preparation of foods. The asparagus soup may be used on almost any but a clear liquid diet. It will fit in with a bland and ulcer management régime as well as with a soft or full tray. The white meat of turkey may be classed with white meat of chicken and used accordingly. It is quite usual for medical men to allow their patients on meat free trays, unless the patient is critically ill, to have meat on Christmas day. What can be more acceptable than a piece of breast of turkey, unless it be a drumstick? Mashed potatoes are, perhaps, more generally liked and can be used on more diets than potatoes prepared in any other manner. Dressing and gravy may be of various flavorings, but chestnut gravy is most delicious. Cranberry jelly or cranberry sauce may not be omitted, the former perhaps fitting in better on a special diet than the latter. In the matter of vegetables, there is more difference of opinion as to which shall be used on the Christmas menu. Carrots and peas are generally liked, however, and in all probability would suit the taste of the greater percentage of patients. A purée of either one would take care of the smooth diet.

The candle salad is selected more for the psychological effect than for the actual ingredients. It is prepared by placing two slices of pineapple, one on top of the other, on a bed of lettuce. A strip of green pepper, to be used as a handle, may be held with one end under the pineapple and the other end inserted in the hole. A piece of banana, about three inches long, is marinated in lemon juice and one end placed vertically in the hole of the pineapple. A cone shaped hole is made in the other end of the banana. Into this hole is placed the large end of a Brazil nut which has been soaked in olive oil. The pointed end of the nut must be slightly chipped. As the tray is served, the chipped end can be made to burn as a candle, and it will hold its flame steadily for some time. Celery and olives are refreshing on a menu, and add to the necessary cellulose for a heavy meal.

Nuts, raisins and hard candies are incidental and may

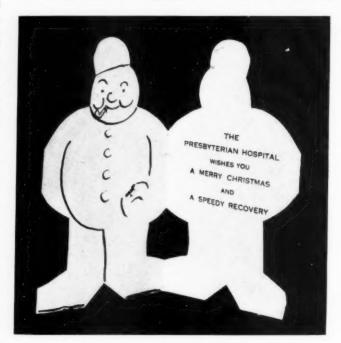
be allowed only on the full tray. Vanilla ice cream, which may be served with or without a sauce, depending upon the diet, is always a delightful ending to a meal. The cherry sauce adds to the Christmas color tone of the tray. Coffee, for those who like it and may have it, adds the finishing touch.

After such a dinner, the supper should be light. Oyster stew, a vegetable, salad and a desert should be sufficient. Also, it would adapt itself to most special diets. The oyster stew strained, the vegetable puréed and the dessert made of bland ingredients would eliminate special

orders for the therapeutic menus.

The mistletoe salad is attractive and is easily prepared. A bed of watercress is placed on a salad plate. Cream cheese, which has been mashed and seasoned, is rolled into tiny balls and arranged in clusters in the watercress, giving the effect of mistletoe. French dressing is best served with this salad. The fresh fruit for dessert may be either one fruit or a plate combination of an apple, a tangerine and a cluster of grapes, which may be kept in the patient's room if desired.

Thus, the Christmas menu is planned for all diets but that of the diabetic patient. The latter, of course, presents a different problem, since there is such a wide variation, or rather restriction, in the foods allowed. The dietitian, however, need not be at a loss, since a bit of substituting here and there will help. Turkey, where possible, will be included, and cranberry jelly made with saccharine is palatable. A salad of a slice or



A snow man wishes the patients a Merry Christmas.

two of tomato, cut in the shape of a poinsettia and garnished with a sprig of parsley, gives a desirable effect. The fruit cocktail tastes better when it is served in a grapefruit basket, and a decorated nut cup will make a few nuts seem like more. Ice cream made of the allotted cream will appeal to the youngsters especially. Thus, each patient's diet must be worked out individually.

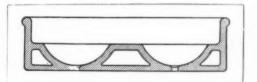
At the Presbyterian Hospital, Chicago, the members of the dietary department spend a great deal of time and effort on all special occasions, but Christmas time always draws the greatest attention. Beginning weeks in advance, we all search the shops, the magazines and our



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own imaginations for ideas that can be worked out cleverly and without great expense. It would be simple to go to a shop and purchase a favor or a place card, but it can never mean as much to the patient as the hand made favor or place card. Work that is done by hand, with attention to the tastes of the individual, is always appreciated.

With this in mind, we plan and make several simple favors for our trays for both private room patients and



wards. Beginning with Christmas Eve and extending through supper on Christmas day, there is some Christmas thought on each tray. Perhaps the most effective and one of the easiest favors to make is a chimney with Santa Claus and his bag. A large sheet of stiff red paper is ruled with white ink to make the effect of bricks, three-quarters by one-quarter inches. This sheet is cut into strips eight inches lengthwise of the bricks and four inches crosswise. Each strip is folded into four sections, allowing an additional one-fourth-inch strip at one end. This flap is pasted under the opposite end, making a chimney four inches high. The top row of bricks may be turned down by cutting a slit at each corner. A small quantity of cheap grade of cotton batting may be used for the filler of the chimney. A Santa Claus sticker, if possible one with only a head and perhaps a bag over his shoulder, is pasted into the cotton. This gives the effect of Santa climbing down into the chimney. Snow crystals sprinkled over this cotton add the finishing touch to the picture. This favor is an appropriate one for the Christmas Eve tray.

For the breakfast tray, especially if the lighted candle salad is not used at noon, there are two attractive candle standards that can be used. One consists of a small nut cup covered with red crêpe paper. A handle may be made of a strip of stiff red paper, one end of which should be pasted on the bottom and the other in the inside of the cup. This cup is pasted on a flat frill of crêpe paper for a standard. A marshmallow is placed in the cup and a

four-inch candle stuck into the marshmallow. This makes an impressive piece when the candle is lighted. The other standard is, perhaps, a simpler one. It is made by pasting a green gum drop on a red card. A candy mint with a hole in the center is inserted into the side of the gum drop for the handle and a small birthday cake candle is placed in the center of the gum drop. The patient's name can be printed on the card with white ink.

A favor our ward patients have enjoyed is a Christmas tree cut out of stiff green paper. A red candle is fastened flat against the tree by means of a piece of string inserted through the center of the card and tied in the back. "Merrie Christmas" is printed with white ink alongside the candle and a silver star sticker is pasted on the top of the tree.

By means of a hectograph or of a mimeograph, original designs may be easily worked out. The hectograph, which can be bought for a nominal sum, allows for the use of cuts of various colors more readily than the mimeograph. It can likewise be used at other times in the department for making copies of diet kitchen forms. By means of the hectograph, we outlined a snow folder that was unusually attractive, especially to the youngsters.

To serve the nuts or candies or both at dinner, a large size nut cup lends itself well. This can be simply and effectively decorated by pasting a strip of red crêpe paper around the cup and fastening the ends down with a Santa Claus or any other Christmas seal. The supper tray can be slightly dressed up by means of a sprig of holly or a bit of evergreen left from the large pieces that are used as decorations on the various floors.

These bits of Christmas cheer can all be made at a nominal cost. The time and energy involved in their preparation are not great, but the satisfaction derived from them is surprisingly gratifying. Were we to disregard the patient's viewpoint in the preparation of these decorations, we would still feel almost justified in preparing them because of the interest they create among the diet kitchen employees. The employees enjoy assisting in the planning and preparing of these specialties and they are spurred on to their best efforts in the preparation of the food and in the actual setting of the trays. In their ardor to please the patients, their disappointment at having to work on Christmas day is alleviated.

One dietitian last year was heard to say that it is more fun to work on Christmas day than on any other day in the year and this explains what another dietitian meant when she said that the true Christmas spirit is more keenly felt in a hospital than in any other place.

Perfecting an a la Carte System in Hungarian Hospitals

An à la carte system of food service is in vogue in Hungarian hospitals and has been since the system was perfected by Dr. Aladar von Soos at the Royal Hungarian University Clinics, Budapest, two years ago. Doctor Von Soos described the plan as he had worked it out at the meeting of the dietetic section of the American Hospital Association in Atlantic City, June 17-21, 1929.

A large card is placed in the diet kitchen and shows the cost of each item. A certain dish may be valued at two units. The patient is allowed 200 units a day. The dietitian may select anything from the range of foods listed, provided it does not exceed 200 units in cost. It is not necessary, however, to see that each patient has 200 units.

RESEARCH PROVES ANTI-RACHITIC PROPERTIES OF COCOMALT



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Radiograph of the tibia of a vachitic albino vat showing the wide zone of decalcification, the so-called rachitic metaphysis. From this point on, a fraction of a gram of COCO-MALT was fed daily in addition to the basal ricketsproducing diet (Ration 2965).



The same bone eight days later showing the beginning of the curative process. Note the deposition of calcium in the provisional zone of calcification.



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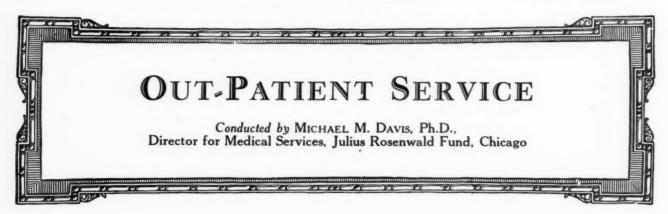
Cocomalt is not a medicine. It is a nourishing, easily digestible, natural food with a delicious chocolate flavor. Physicians who experience difficulty in persuading patients to drink milk will find Cocomalt palatable and invaluable.

Cocomalt increases the caloric value of milk 70%. For that reason alone it is useful in diets of convalescents when the physician wishes to build up body weight as rapidly as possible. Served with milk, Cocomalt makes an excellent supplement to the average dietary, adding proteins of the highest biological quality, mineral elements (especially calcium and phosphorus) in the proper proportions and vitamins A, B (complex) and D.

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The Diagnostic Clinic—Its Virtues and Its Shortcomings*

HAT is a diagnostic clinic and how does it function?

In discussing this subject it is well to define this type of medical service, to describe several "going concerns" and to point out significant similarities and differences in the plan, scope and organization of various diagnostic clinics. A diagnostic clinic may be defined as a clinic that limits its work to the study and diagnosis of an ambulatory patient's condition without any responsibility for treatment. From the point of view of the public, such a clinic may be regarded as a response to the increasing efficiency, complexity and cost of adequate diagnostic service which often places it beyond the reach of persons of moderate means, as well as of the poor.

From the point of view of the private practitioner of medicine, a diagnostic clinic may be regarded as a response to the professional need for consultation service which, through the advance of medical specialties and technique, has become more and more difficult for the average practitioner to secure for the benefit of his patients and for his own growth in professional knowledge. As a part of an out-patient clinic, the diagnostic clinic may be regarded as a coordinator of the various general and specific services required for cases presenting obscure or difficult problems for diagnosis.

How the Consultation Clinic Functions

Diagnostic clinics in which the clientele is limited to patients referred by physicians are called consultation clinics. Both diagnostic and consultation clinics have been established in connection with the out-patient department of a hospital, in the hospital itself or as a part of a pay clinic or a group clinic. Pay clinics are clinics for persons of moderate means in which physicians are paid and the fees approximate the cost of the service; the group clinic is one in which a voluntary association of physicians use a certain plant, equipment and organization in common for their private practice. The first three clinics described are consultation clinics.

The diagnostic clinic at Research Hospital, Kansas City, Mo., is organized on a broader basis, patients being admitted at their own request as well as on reference from physicians. The Mayo Clinic, Rochester, Minn., and the Henry Ford Hospital, Detroit, do not limit their clientele. The Mayo Clinic is an outstanding example of the group clinic

The consultation clinic at the Massachusetts General Hospital, Boston, was established about fifteen years ago for the benefit of patients of moderate income and to assist private physicians who have such patients in their care in cases of doubtful diagnosis. It is an integral part of the out-patient department. The main differences between it and other out-patient clinics are that: Patients are accepted only through physicians; all patients are referred back with a report to the doctors who sent them; no treatment is given and no information is given to the patient or any other person except with the consent of the referring physician. Twelve appointments are usually made for each clinic session, between 1,200 and 1,300 patients thus being seen in the course of a year.

The applicant for a diagnostic examination, like the prospective client for any other clinic, is seen by the admitting clerk. Unless the referring doctor has specifically requested examination in a particular clinic, she goes automatically to the general medical clinic. Most of the patients admitted go first to this service. Even those sent first to a specialty are often referred back for a medical examination. While the doctor's requests are acceded to whenever possible, the patient's need is the determining factor.

The chief of the medical clinic is responsible for all the cases sent to his clinic. Findings of the consultants on the various services are reported to him together with all information such as the results of x-rays, blood tests and other special examinations. He then writes the diagnostic report. This is in the form of a letter to the referring physician and consists of a brief history, general physical findings and recommendations. This letter is reviewed and signed by the director or by one of his assistants

The general admission fee to the clinic is \$10 covering all needed consultations. Additional fees are charged when necessary. Expenses are deducted from the fees taken in. The remainder is divided among the physicians working in the clinic for the current month, on the basis of the number of patients seen and the time spent in the clinic. The junior assistants and other consultants are paid according to this plan. The clinic chief receives in

^{*}Abstract of the 1929 report of the committee on out-patient work, of the American Hospital Association.

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addition a fixed salary of \$75 a month to recompense him for the added responsibility of writing the medical reports and for consultation with his junior assistants. The urologist also receives a fixed salary of \$25 a month in addition to the amount due him for clinic service. This clinic is self-supporting.

Since this clinic is for persons of moderate means, the question of eligibility is important. Because the recommendations of the referring physician are considered sufficient, no special inquiries are made of patients.

The clinic appears to serve the doctors of outlying districts to a greater extent than it does those in Boston. Patients are referred from all over the state as well as from neighboring states, and they have occasionally been sent from cities in California and in Canada. The existence of the clinic is made known through a professional announcement which appears in the New England Journal of Medicine.

Various Methods in Use

The diagnostic clinic at Harper Hospital, Detroit, was established six years ago for patients of moderate means referred by physicians. It is not at present a part of the out-patient department. All patients are hospitalized, usually for about three days. The number accepted at any one time ranges from five to eight, eight being the limit. The patient, who always comes with a letter from the referring doctor, goes through the usual hospital routine.

The doctor referring a patient cannot send persons directly to specialists nor is he expected to share in the procedure. The director of laboratories, who is in charge of the clinic, plans the patient's routing. There is no special diagnostic clinic staff. Usually the diagnostic service is given by the heads of the various departments. The director of the clinic pools all the reports and signs the letter sent to the referring physician.

The clinic was advertised in local and state medical

journals for a year and then discontinued.

As at Massachusetts General Hospital, no inquiry is made as to financial eligibility. The hospital assumes that doctors would not refer patients able to pay specialists in their private offices. About fifty or more physicians, many of them members of the Harper Hospital staff and some from near-by Canadian cities, have referred patients.

The diagnostic clinic of the Research Hospital, Kansas City, Mo., like those clinics already described, was established to serve patients unable to pay the private office fees of specialists when consultation became necessary. William Volker, Kansas City, was financially responsible for starting it in 1924 and has met all deficits. Patients are admitted to this clinic both on reference by physicians and at their own request. It is entirely diagnostic. From November, 1924, to November, 1928, 5,043 patients were seen. Of these, 2,303 came independently; 2,740 were sent by physicians.

The patient's routine is as follows. He is first seen by one of the younger physicians who takes his history. Then he is sent to the examining physician. On the completion of the examinations and tests, an internist sees the patient. His job is to review the assembled data and to recommend the treatment to be carried on by the patient's physician. Patients are not accepted directly for a specialty but must go through a complete examination. A complete report is sent to the physician. This includes the history and all findings, whether positive or negative. It is dictated and signed by the director of the clinic and is practically a copy of the data collected.

Patients who say they have no physician may be given a verbal report but no written reports are given them.

The regular fee for the diagnostic service is \$50 but this is reduced to as low as \$25 for those patients for whom a larger fee would be a hardship. The amount of the reduction is determined by the director of the clinic. The examining physicians do not know what fee is being charged. The part-time personnel—the physicians who take the histories, the roentgenologist and the examining physician—receive a monthly salary. The other physicians are paid according to the number of days a month they attend the clinic.

Since most of the patients are from out of town, the clinic has found it impracticable to check their statements of financial ability. Two hundred and seventy-eight members of the local profession—more than half of its membership—have used the clinic, 161 of them more than once. At the time of the establishment of the clinic a notice was sent to the profession.

The diagnostic service of the Cornell Clinic, New York City, is in the department of medicine. Like the consultation clinic at Massachusetts General and the diagnostic clinic at Harper Hospital, this service is primarily intended for patients of general practitioners who are able to meet fees for minor illnesses but who are unable to pay specialists' fees when these become necessary.

Each patient who goes to the Cornell diagnostic clinic is first given a general examination and then such exploratory tests as may be indicated are called for. After these are completed, the patient returns to the doctor who first saw him. This physician sums up all the available data and reports in writing to the referring physician. The cost to the patient is \$10, including as many visits to as many specialists as may be necessary to reach a diagnosis, and also routine blood and urine examinations. Additional laboratory and x-ray work is charged at regular clinic rates. This clinic aims to render service at cost, including remuneration to physicians.

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The clientele is limited to patients of moderate means and each patient is carefully questioned to determine his eligibility. Patients who are referred by physicians are not accepted for treatment by the clinic but are sent back to their physicians unless it is requested in writing that treatment be given. Approximately 15,000 patients were sent to the clinic for diagnosis during the first six years of its existence. These patients have been referred by 4,000 individual physicians, living in the states of New York, New Jersey and Connecticut within a radius of twenty-five miles from the location of the clinic. A number of physicians not on the staff of the clinic have sent more than a hundred patients during this period. One has sent 400 patients.

A Self-Supporting Out-Patient Service

Different in purpose from the clinics already described, which were established primarily to aid persons of moderate means, are the diagnostic clinics at Mayo Clinic, Rochester, Minn., and the Henry Ford Hospital, Detroit. In both these institutions diagnosis is more often than not preparatory to treatment there, and the fee scale is based on the usual charges made by private practitioners.

The Henry Ford Hospital runs no special diagnostic clinic. All new patients are given a complete examination and are referred to the specialty indicated. Patients are taken both on a consultation basis on reference from physicians and for diagnosis at their own request. There is no special diagnostic clinic staff. The entire hospital staff may be called upon. In general, one physician is responsible for each case, a doctor in the division in



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which the case falls. A report is sent to the referring doctor by the staff. A type of report suited to a layman

is given the patient.

The Henry Ford Hospital out-patient service aims at self-support but does not make a surplus over expenses. There is no special diagnostic clinic fee. All new patients are charged a special fee for the first examination. The out-patient schedule of charges lists thirty-two items. The fee schedule is said to be equivalent to those in effect throughout the local medical profession. Physicians are paid on a salary basis.

The Work of the Mayo Clinic

The Mayo Clinic is not a local institution. Patients go there from all over the country. It has no special diagnostic clinic. Some patients are referred by their physicians for diagnosis only. Others are accepted at their own request for diagnosis plus treatment. The routine of all patients during the period of diagnosis is the same whether the patient is to be treated at the clinic or by his home physician. One physician supervises the examination of the patient during all stages. At the conclusion of the examinations, the referring physician receives a report that gives all details, including laboratory, x-ray and other findings. This report is prepared and signed by the examining physician. It is regarded as a professional medical report. The patient is given a verbal report and an explanation of his condition coupled with such advice as it seems proper to give him under the circumstances.

The Mayo Clinic is operated as an organization for giving high grade medical service at a reasonable cost to the patient and a net profit to the association that owns and operates the clinic. Fee rates are not fixed, although a certain average or medium fee is established. These are reduced or increased according to the financial circumstances of the patient. They vary with the type of service. There is no uniform admission fee. All physicians are paid a salary commensurate with their special qualifications and equivalent to what they would probably

command in private practice.

The clientele of the Mayo Clinic is not restricted to any particular economic type of patient. The rich, those in comfortable circumstances and the near poor are at one time or another patients there. Ordinarily the clinic accepts the patient's word as to his financial condition, but at times the patient's circumstances are investigated through the usual commercial rating agencies

and fees are adjusted accordingly.

All the clinics described were established to provide opportunities for consultation for the general practitioner who is puzzled about his patient and to enable him to have x-rays and tests made that he cannot undertake himself. The clinics at Massachusetts General, Cornell, Harper Hospital and Research Hospital limit their clientele to persons of moderate means who cannot afford specialists' fees. The Mayo Clinic and the Henry Ford Hospital admit patients of all economic grades.

Four types of organization are illustrated by these various clinics: a special clinic set up as an integral part of the out-patient department; diagnostic service in which the patient is hospitalized; a separate diagnostic clinic attached to a hospital that has no other out-patient service and the diagnostic clinic as a service that is routine for every new patient. These clinics admit patients either only on reference from physicians or with or without such reference. They admit them for diagnosis only or, in some instances, for treatment as well as diagnosis.

In every clinic studied one physician is responsible for reviewing and interpreting the consultants' opinions and other data and for writing the final report. This is signed by the head of the out-patient department or one of his assistants, by the clinic chief or by the director of laboratories. The medical report on the patient's condition is in every case sent to the referring physician to whom the patient is expected to return. The patient is in most cases given no formal report. Occasionally when he has come without reference by a physician he is given a simple report suited to a lay person.

In the clinics serving persons of moderate means, the fees for diagnostic service are of two types: a fee of \$10 that covers all needed consultations and the routine laboratory work plus additional fees for x-rays and special laboratory tests, and inclusive fees of from \$25 to \$50 that cover everything. Physicians in the clinics for persons of moderate means are paid according to the service given, except at Harper Hospital where they are paid nothing. At Henry Ford Hospital and the Mayo Clinic the medical staffs receive full-time salaries.

It is difficult to determine accurately whether or not a special clinic that is part of a hospital or an out-patient department pays its own way. So much depends on the basis upon which charges for overhead are determined. For this reason conclusions cannot be drawn from the fact that the two clinics that charge \$10, plus special fees, are reported to be self-supporting while those that charge from \$25 to \$50 and more are reported not to be.

What, then, are the advantages and disadvantages of the diagnostic clinic? Perhaps its outstanding virtue from the medical standpoint is that it organizes the diagnostic process for both patient and doctor, thereby promoting coordination of the findings of specialists through the brain of a single clinician. The diagnostic clinic thus strikes directly at perhaps the greatest evil that has resulted from the growth of scientific medicine and the development of specialism. The well-to-do patient who goes from the office of one specialist to another may get a complete study of his symptoms and organs, but the diagnostic clinic can supply a study not only complete but coordinated.

Economies of the Diagnostic Clinic

The diagnostic clinic, through the joint use of equipment, technical knowledge and saving of time of the specialist, may be an economy to the patient. He may be able to obtain the same service through the clinic at a less rate than would otherwise be possible even if he pays the full cost of the service. The extent to which the diagnostic clinic lowers the cost of diagnosis and becomes an economy to the patient depends upon the type and efficiency of its organization and the extent to which the physicians and the other controlling authorities pass on to the patient, in the form of reduced fees, any of the economies that result from this form of organized medical

The disadvantages of diagnostic clinics depend on the point of view. The hospital or out-patient department that develops a diagnostic clinic is likely to benefit its whole service through an increase in the medical efficiency and better coordination of its staff. It may, however, face criticism from outside physicians usually due to misunderstanding, although several excellent diagnostic clinics have started and are maintained with the full backing of the local profession and without any observable criticism.

From the administrative standpoint, the diagnostic

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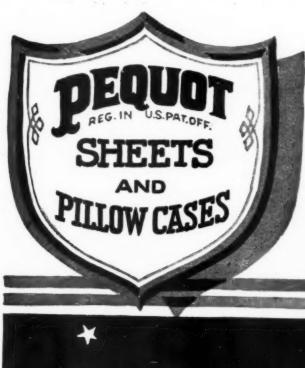
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clinic presents little difficulty except in respect to the admission of patients. It is not always easy to limit the intake of patients to those referred by physicians even when it is determined to do so, since patients apply in evident need of diagnostic service who are strangers in the community or who name no physician with whom they have had previous contact. These patients often demand the name of a qualified physician to whom they may go for initial examination or for treatment. These administrative difficulties, however, are matters of detail. If they are handled with reasonable tact and with the advice of the clinic staff, they present little difficulty.

From the standpoint of the general public, the chief criticism of the diagnostic clinic is that it does not go far enough. Many of the diagnostic clinics for persons of moderate means limit themselves to diagnosis only. Their statements say emphatically that all patients are returned to referring physicians, even if the patient wishes to give up this physician. The clinic will not send him elsewhere. Since reports on a patient's condition are returned to the doctor who referred him, he must return to this physician if he is to profit by the diagnostic service he has received. Patients have been known to complain about this at several of the diagnostic clinics. "Are we chattels that we are to be handed about in this way?" asked one patient.

The contact with the physicians in the diagnostic clinic leads some patients to have confidence in the physicians and to wish them to carry out the treatment, believing them more competent than the doctors with whom they were formerly in touch. Sometimes the physicians in the clinic agree that this is the case. No clinic has established a policy of attempting to pass upon the qualifications of the referring physician to ascertain whether or not he has the facilities and skill needed to give the patient the particular care he has been found to need.

In limiting the service of a diagnostic clinic strictly to diagnosis and to patients referred by the medical profession, the institution is striving to be fair to the outside physician, the general practitioner. The problem of being fair to the patient and furnishing him with more than the half-loaf of diagnosis is not yet solved.

How New Jersey Provides for Its Mental Patients

Providing treatment rather than custodial care for mental patients in the New Jersey state hospitals for mental disease has been the policy of those in charge, according to a recently published bulletin on county and state welfare work in New Jersey. It is the hope of the hospitals to restore as large a number of patients as possible to safe and productive work in the community.

Each patient is given a comprehensive physical examination, including an x-ray of the teeth, laboratory study of the blood chemistry and examination of the eyes, ears, nose and throat by a specialist, followed by specific treatment for any abnormalities discovered. The mental examination is equally thorough. The therapeutic measures prescribed take into consideration both the physical and mental condition and include a variety of baths, packs, electrical treatments, special diets and medication, with supervised physical exercise, amusements and an extensive system of occupational therapy.

When the patient is sufficiently improved to warrant a trial visit home, the psychiatric social service division investigates the surroundings, advises the family as to methods of promoting the best interests of the patient, assists in procuring work and then supervises the patient for one year after which, if the cure persists, he is discharged from the hospital records.

In addition to the treatment of patients in hospitals, the hospitals have developed a system of mental hygiene clinics at which persons with nervous and mental disorders may receive advice and treatment at an early stage of their difficulties.

The two state hospitals for mental disease in New Jersey are at Greystone Park and Trenton. Plans are under way to build a third at Hilldale.

Extending the Infant Welfare Program in Queensland

To remedy a serious breach in the infant welfare program in Queensland, Australia, the Queensland nurses' registration board has provided for not less than six months' training in child welfare, the Journal of the American Medical Association reports. This training will be given at the child welfare training center for all nurses holding only midwifery certificates. Not less than four months' training must be had by nurses holding general, general and midwifery and mental certificates. The curriculum of instruction and lectures provides for the antenatal and postnatal care of the mother and the child. The practical side deals with the preparation of artificial foods, weaning, the use of feeding utensils and the actual care of the mother and the child.

Reduced Hospital Bills, and Free Work

Hospitals should not lose in bad debts more than 5 per cent of their gross earnings, the Western Hospital and Nurses Review emphasizes in a discussion of getting credit for free work. Many institutions, it says, operate on a basis of a 2 or 3 per cent loss. This loss, however, should be considered as an operating expense and not as free work. If an accurate account is kept of all free work and presented systematically for the information of the public, there is no reason why the institution should not be reimbursed by the community for the services rendered.

The article says: "One person only in the hospital should have the power to reduce rates—the manager or superintendent. All requests for rate reduction should be made in writing, stating fully the nature of the request. These rate agreement slips may be made a matter of record and filed alphabetically until after the regular hospital audit is made. Records of free work should be kept as carefully and in the same manner as if the institution expected to be paid for the service.

"Some of the headings that might be used to classify various types of free work include: courtesy—rate reduction to employees, physicians on the staff, graduate nurses, ministers; endowments—rebates granted patients and such rebates charged against the income of endowment funds of the hospital; charity, both voluntary and involuntary, the latter including such cases as automobile accident cases or other emergency admissions; bad accounts—cases in which the hospital has extended credit unwisely or in which the follow-up work has been poorly planned.

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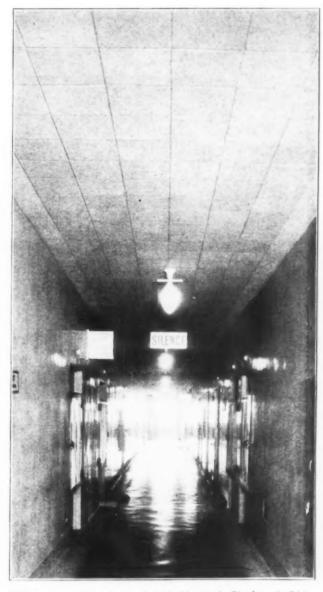
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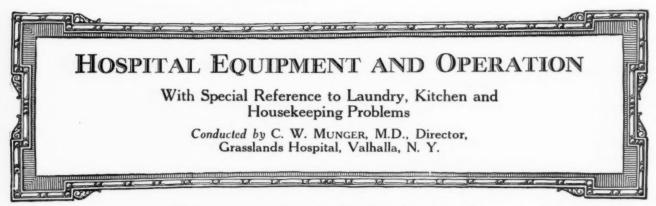
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How to Plan and Maintain a Lock and Key System

By F. R. RUSSELL

Business Assistant, Grasslands Hospital, Valhalla, N. Y.

THE lock and key system of any sizable hospital presents no simple problem if there is to be adequate privacy and protection of property.

With locks, simplicity of operation is the best guarantee of security. Institutions equipped with good locks should be able to maintain perfect control of them with a minimum of effort; yet some hospitals seem to have no end of confusion and trouble.

Locks are an unknown quantity to the average hospital worker. In a great many cases, lock trouble is taken as a matter of course, and the carrying of a pound or two of keys about one's person is often accepted as inevitable. The uninitiated are inclined to feel that the more keys that are needed to control the lock system, the greater will be the security.

Door locks may be divided into two groups, the cylinder or pin tumbler lock and the standard or lever tumbler lock. The cylinder lock offers the greatest security and can be had in many styles and types, including padlocks, all controlled by one master key. The standard lock is the type usually seen on interior doors of residences. It can also be divided into submaster groups. However, not as many locks can be controlled by one key or as many groups established as for the cylinder lock.

The cylinder lock should be used on all outside and important inside doors. It may, however, be used on all doors and in certain cases should be, especially if the institution is divided into many working units. The number of cylinder locks that can be controlled by one master key is practically unlimited. These locks may be grouped in smaller lots with a submaster key controlling each group and with the master key controlling all. For cupboards, medicine cabinets, panel boxes and similar equipment, a cylinder lock should be used. This should, of course, be smaller than the door lock. By using a cylinder lock it is possible to have all such equipment under the control of a grand master key and also subdivided into smaller groups under submaster keys for each ward or department. Lockers for employees may also be controlled by the small cylinder locks. However, since no great security is usually needed, the ordinary lock used to equip lockers, if it is master keyed, is sufficient. It is obvious, therefore, that three grand master keys would

be enough for opening all locks in an institution that maintains such a system.

The advantage in being able to establish submaster groups under the control of the main master key is that persons who have certain sections under their supervision, such as a ward, storeroom, kitchen or laboratory, may have one key that will control all of the doors in this section, but in this section only. In some cases the locks of an entire section may be identical so as to respond to the same key. Such a plan is useful for doors to the patients' rooms on a given section, which are only locked when not in use and which should all be accessible to the head nurse. Where padlocks are used on many window gratings and where the gratings are unlocked only for the washing or painting of the windows, it is as satisfactory and is possibly less expensive to have these locks all keyed alike. The same system could apply to the electric panel boxes, since only the electricians would need to have access and there is no reason why they should be prevented from unlocking any or all.

Such locks of a section as should be accessible to a number of persons may be keyed alike. In psychiatric hospitals all nursing personnel of a section must be able to lock patients into or release them from their rooms and all personnel must have access to utility rooms. All such locks are keyed alike. On the other hand, those sections that are for the charge nurse only may be keyed differently from other rooms, with all locks responsive to the head nurse's submaster key.

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In hospitals with poorly planned locks, many employees must carry the main master keys. This would not be necessary if the lock system had been properly designed and maintained. For example, it is possible to provide that one person may have the supervision of one half of the wards of a hospital without access to the other half. To accomplish this, each ward must be so equipped that one key will control all of the door locks and another all of the cupboard locks. Then all of the locks on the various wards in one half of the hospital can be so set up that one submaster key will operate all of the door locks and another all of the cupboard locks yet with all locks under the control of the grand master key of the institution. Furthermore, it may be necessary for the super-

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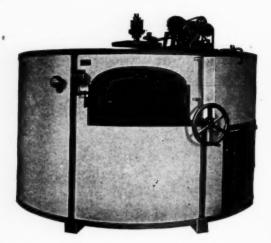
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visors of the different divisions of the hospital to have access to certain rooms used in common. These rooms may be made to unlock with each submaster key. Other than this the submaster keys can operate only the locks for their respective divisions. Many useful combinations of a similar nature may be devised.

When proper care is given to the establishment of groups so that all of the doors under the supervision of a given department head are in the group, the department head need have only the key controlling these doors. If such doors are not properly grouped, it is then necessary for main master keys to be issued controlling all doors in the building, thus permitting the housekeeper, for instance, to have access, quite unnecessarily, to rooms entirely under control of the nursing department. Additional locks may be added to any group when needed so that once a system is established it need never become obsolete. The main master keys should be issued to high officials. The night watchman should be given the master keys for the doors only, since it is not necessary for him to have cupboards and cabinets under his supervision.

Room Locks Can Be Differently Keyed

Locks for employees' living quarters should also be given careful thought. These quarters are often in detached buildings, or they may be special sections of the main building. If all locks are of the cylinder variety or if all are standard type, each employee needs only one key to gain entrance to his room as well as to the main entrance door. Room locks can be differently keyed but so arranged that floor maids for instance can carry pass keys opening rooms in one section only. It is possible so to key the closet doors that the employee's key will open it but the maid's pass key will not. This building, or section, will have, of course, a submaster key controlling all of its doors, the locks still being under the control of the grand master key of the institution.

Not only is it a convenience to have a number of locks controlled by one key, but this plan also prolongs the life of the lock. When many keys are together and are very much alike, it is difficult to pick out the proper key for a door without first inserting a few in the lock. In most cases the damaging of locks is caused by attempts to use the wrong keys. Often the key is left, broken, in the lock or the lock is forced and broken.

Extra locks and cylinders for each group should be kept in stock at all times. Each should be carefully labeled so that it will be used with the proper group when it is needed. With extra locks on hand it is but a few moments' work to replace a disabled lock. The broken lock should be sent to the manufacturer for repairs. It will thus receive the proper attention and if new parts are needed they will be exact in detail. Since these locks are all controlled by master keys, they will also be repaired to work under the same keys.

If no extra locks are kept in stock and a lock is in need of repair, that door is left unguarded for a much longer period than when another lock is available for immediate replacement.

All keys should be carefully recorded. Records should be kept of every lock. These records should show the location and serial number of the key that operates this lock and also the submaster group to which it belongs. The keys should be kept in a securely locked key cabinet large enough to accommodate all keys and with long hooks to permit the placing of all keys for a given lock upon one hook. Each hook should be numbered in consecutive order. It is advisable not to show on the key board what locks the keys operate, for if by chance un-

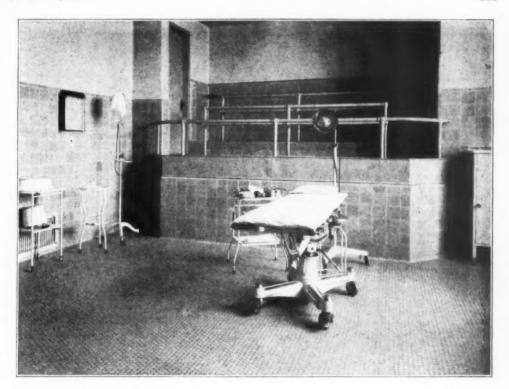
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There are special MOSAIC TILES for hospital requirements

An operating room in Bethesda Hospital, Cincinnati, is illustrated. Architects, Samuel Hannaford & Sons. Wainscot of 6x6 French gray Mosaic Satin Finish Wall Tiles, with 6x2 cap and cove of same color. The floor is of 1¼-inch hexagons, light gray Mosaic ceramics.



The name "Mosaic" is applied to all tiles made exclusively by The Mosaic Tile Company. This name is stamped on all Mosaic Products, which include floor, wall, ceiling and decorative tiles of the widest description. The word "Mosaic" should be used in writing tile specifications.

S POTLESSNESS in detail, greater than mere general cleanliness, is made more available through the use of Mosaic Tiles in operating rooms, delivery rooms, sterilizing rooms, dressing rooms, utility rooms, kitchens and elsewhere in modern hospitals.

The tiles themselves, impervious to stains, chemicals, moisture and wear, are quickly and easily cleaned. They may be kept clean with little effort, be-

cause nothing penetrates beneath their vitrified surface.

To make this easily provided sanitation easier still, there are special Mosaic "trim" tiles, to give rounded corners where desirable—rounded bases at the foot of walls—rounded caps for the tops of tile wainscots.

This is one of the features in favor of the use of Mosaic Tiles in hospitals. Our many years of experience with hospital requirements are also at your service, and our design department will gladly co-operate with you in drawing up plans and specifications.

The MOSAIC TILE COMPANY, 812 Coopermill Road, Zanesville, Ohio

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O'BRIEN'S 2-Hour Varnish

Unexcelled for Hospital Finishing

WITH this Varnish, Floors, Woodwork, Furniture or any other surface, either inside or outside, can be finished at, say 8:00 o'clock in the morning and the finish dry and ready to be put into service again at 10:00. The finish will be just as durable, in fact more durable than finishes provided by any slow-drying varnish. O'Brien's 2-Hour is entirely new, completely different and decidedly better than any similar product you may now be using. There's none other like it, none other quite as good for Hospital use.

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Please send a free sample together with full particulars ing your 2-Hour Varnish.	regard.
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authorized persons should gain access to this cabinet they could not tell to what locks the keys belong. Records showing what locks the keys operate should be kept in the office safe, cross indexed alphabetically and numerically. The number of each hook in the cabinet should be used as a code number, alphabetically, so that keys wanted may be easily located and, numerically, to show what key is on a certain hook in the cabinet. Duplicate keys for each individual lock should always be on hand.

If all the individual keys of a lock are lost or if duplicates cannot be spared to have new keys made, it is possible to order duplicate keys by the serial number from the records. Additional keys should be ordered from the manufacturer. These keys then will be correct in every detail in addition to having the same serial number stamped upon them as upon the other keys to be used for this lock.

The door or room number should not be stamped upon the key. If properly recorded, the serial number will always give the location. When the serial number only is on the key, an unauthorized person coming into possession of important keys that have been lost or mislaid has no means of telling what doors these keys operate. Moreover, if a lost key is subsequently found and turned in, the serial number on it is sufficient for identification.

A record should be kept of all keys issued and to whom they are issued. A simple method of keeping this accurately is to place a small durable tag upon the appropriate hook at the time a key is given out. On this tag should be the name of the person and the date the key was issued and notation as to any deposit collected from the holder of the key.

It is advisable to receive a deposit for keys issued to employees for their rooms and lockers. This deposit is not intended, necessarily, to cover the cost of the keys but to give the employees an incentive to return his key when he leaves. The deposit makes loss of keys expensive enough to encourage proper care. The amount of the deposit should be sufficient to accomplish this purpose.

Reliable lock manufacturers will assist in planning thorough lock systems. The average architect does not know the routine working plans of the institution, so it is always advisable for the owner or consultant to confer with the manufacturer's representative and plan the system in its smallest details. Careful preliminary planning is the best guarantee against trouble. Next in importance is the need for the entire lock and key system to be controlled in operation by one person who has studied the subject.

Advantages of Aluminum Chairs for Institutional Use

Aluminum, commonly considered suitable only for the construction of cooking utensils and novelties, is now used in the manufacture of furniture. Aluminum furniture has a weight only about half of that of wooden furniture and it has the further advantages of being fireproof and capable of withstanding severe racking abuse, according to the manufacturers. Chairs made of this metal have found a wide institutional market.

Aluminum chairs, made as they are of a distinctly modern metal, satisfy the current demand for beauty and at the same time combine pleasing appearance with utility and economy. Chairs of other metals would be too heavy to make their general use feasible, the manufacturers point out. Chairs, fabricated from the strong aluminum

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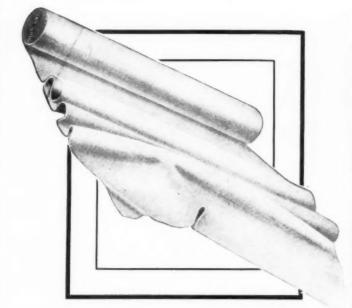
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Use it - Launder it Use it - Launder it

Use it and Launder it again and again

> it will still be Waterproof

This white felted sheeting contains no rubber. It is waterproofed by a special process which permits laundering and re-laundering without affecting its waterproofing qualities.

We call it Swansdown because of the fine, soft nap that makes it comfortable to rest on. Particularly recommended for use in maternity departments - can be used in cribs or bassinets without a pad. It is also very welcome to patients who are irritated by the ordinary rubber sheeting.

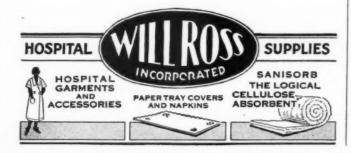
Send for a generous swatch or a quantity for trial. 36 inch width only. The price is very reasonable. 1 to 25 yard quantities, \$1.80 per yard.

Larger quantities, \$1.65 per yard.

WILL ROSS, INC.

457-59 E. Water Street

Milwaukee, Wis.





LYING the air mail to Cheyenne. 'Way down below, the gathering dusk is graying the ground. It will be dark soon, and the postman of the air will need his beacons to show him the way.

There's a beam now, just flashing out. There comes another, twenty miles away. See them string out across the desert-Uncle Sam's land lighthouses, marking the skyways for the Air Mail-lighting them with electricity, though the nearest central station, the nearest power line, be a hundred miles away.

From sunset to sunrise, night after night, in blistering heat or sub-zero cold, hundreds of these life-saving beacons are lighted by small Kohler Electric Plants, generating "city" electricity on the spot with an efficient certainty that is the constant marvel of their caretakers.

Emergency service for hospitals

All in all, over six hundred Kohler plants are working for the U.S. Air Mail, daily adding to the fine reputation that these trusty machines have earned in many fields of service.

Kohler Electric Plants have made a particularly fine record in hospitals, where they are installed to "cut in" automatically in case of city-current failure. They supply 110- or 220-volt current, direct or alternating, operating standard equipment. The coupon will bring detailed information.

KOHLE Kohler Co. Founded 1873				
Kohler Co., Kohler, Wis. Gentlemen: Please send				FIXTURE: M. H. 12-29
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TILE-TEX-

the Silent, Resilient, Beautiful floor tile that never wears out



Egleston Memorial Hospital, Atlanta, Ga., (X-Ray Room) Morgan, Dillion & Lewis, Architects W. A. Lippincott, Inc., Atlanta, Contractor

TILE-TEX resilient floor tile meets every exacting requirement for hospital floors. . . . It is quiet and restful—perfectly sanitary—permanent in color—costs less—and lasts a lifetime! That's why Tile-Tex has been specified for some of the nation's finest hospitals.

Traffic can in no way harm Tile-Tex. Severe foot traffic only polishes its surface . . . ink, commercial acids, and all ordinary floor stains are easily removed with a damp cloth . . . it is impervious to dampness and resistant to fire. Tile-Tex is absolutely guaranand resistant to fire. The lex is absolutely guaranteed to stay down and give satisfactory service even when laid on damp concrete floors, at or below grade, that have not been waterproofed. Investigate Tile-Tex now! Mail the coupon.

The TILE-TEX Company

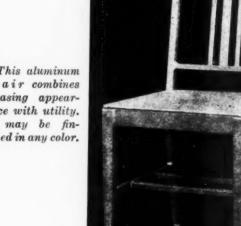
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Chicago Heights, Ill.

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THE RESILIENT FLOOR-TILE
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Send your book "Floors That Endure" and give name of nearest TILE-TEX distributor.
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alloys-the same alloys that are employed in airplane propellers, connecting rods, truck bodies and the likeare strong and enduring. There are no dowels or screws to loosen; the chairs are welded into one continuous piece of metal, eliminating the danger of warping and loosening at the joints.

Chairs made of the strong aluminum alloys will stand up indefinitely under severe service conditions, it is said. In order to duplicate such conditions, a racking test has



This aluminum chair combines pleasing appearance with utility. It may be finished in any color.

been devised and is used at the factory. In this test a weight of 180 pounds is placed on the seat of the chair and the chair bumped back and forth on the rear and front legs at the rate of thirty times a minute. No structural weaknesses occur in aluminum chairs after being tested in this manner for more than 150 hours, it is further emphasized. Wooden chairs, similarly tested, loosen at the joints after but a few hours.

Metal construction is ideal for chairs that are constantly in use in that there can be no destructive splinters. The all metal construction also means a chair that can be easily cleaned as well as one that is fireproof. The initial cost of an aluminum chair compares favorably with that of a high grade wooden chair. There is practically no upkeep on an aluminum chair.

Improved Deep Fat Fryer Is Now Available

An improved fryer is now available for those who do deep fat frying. Not only does the new fryer do away with the usual "kettle on the stove" method of frying but it is economical in that it reduces the expense for fat 75 per cent, according to the manufacturer.

The production of deep fat fried foods is made easy by the new fryer, it is said. A heat control keeps the fat at the right temperature. A feature of the fryer is its fast heat recovery. When a basket of cold food is placed in the fryer, an automatic control turns on a powws ece

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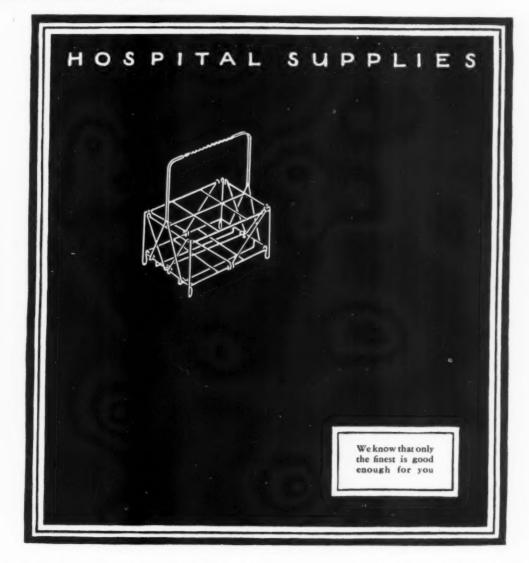
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American hospital supplies are tough and rugged. They withstand hard, rough usage. They keep the goodness built into them, longer. Carelessness has less effect. They last a long time. You buy them less often.

Too, they are beautifully designed. The edged tools are finely tempered steels; all instruments are properly balanced for sweet, swift work; the silver ware is pleasing in shape; the rubber goods fit and are comfortable; the syringes and needles are accurately made, sharp, de-

pendable... and so on from page one to page 188 of the catalog.

ALL American supplies have abilities to supplement the able, swift and skillful minds and fingers of your physicians and surgeons and nurses.

You'll find them tough and able and with a thorobred design. You'll find that their cost price to you is low and fair and just and square. All of which are reasons for the confidence you folks have in us.

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THORNER'S Silver Service



Thorner's Silver Service is made of 18% Nickel Silver with a quadruple silver plate. Wears a lifetime. Replacement through breakage is forever eliminated. It is never affected by wear or polishing.

Illustration features Thorner's Improved Three-Compartment Hot Water Plate. Tea Set is seamless with inside rounded bottom and reinforced band around top. Covered Soup Cup with Silver Soldered Handles. Sherbet Dish, Gravy Boat, Individual Napkin Ring and Tray Marker, Bud Vase, Salt and Pepper Shakers and Superior Grade Sectional Flatware.

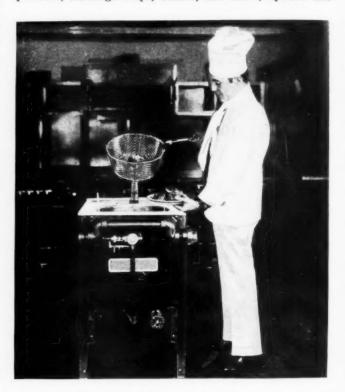
THORNER BROTHERS

Importers and Manufacturers of Hospital and Surgical Supplies

> 135 Fifth Avenue NEW YORK CITY

erful speed burner. Heat is driven through tubes in the kettle, thus preventing the fat from chilling. As a result the fat is so hot that it sears food immediately. Because of this, the food retains its texture and flavor and does not become soggy.

As an example of the economy of the fryer, it is pointed out that the same fat can be used for French fried potatoes, Saratoga chips, cutlets, fish cakes, oysters and



doughnuts without affecting the flavor. If the fat is strained once a day, it can be used over and over for several days. It is kept so hot that it cannot become rancid. Sediment falls to the bottom and the fat is kept clear and clean.

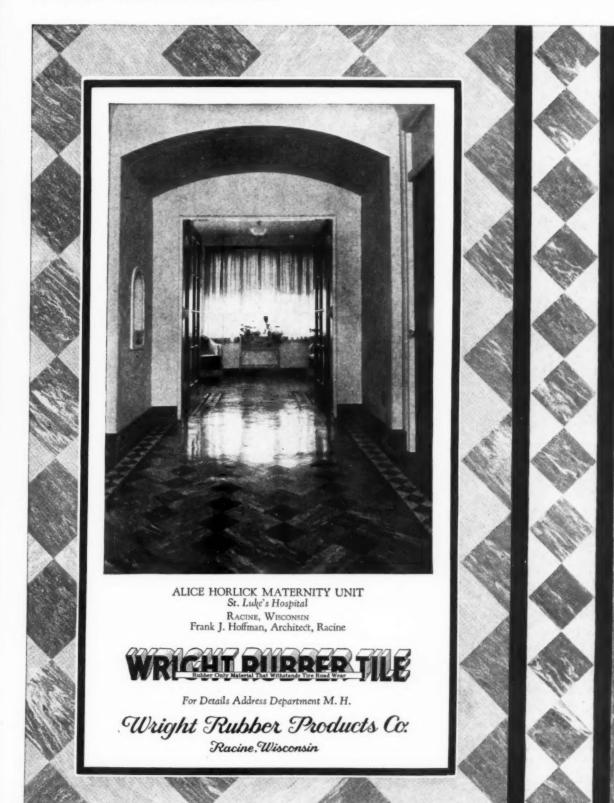
Some special construction features of the fryer are: It has a one-piece cast iron kettle that eliminates danger of leakage; fat cannot reach the flame; the strainer keeps crumbs from dropping to the bottom; radiation is reduced by the heavy insulation of walls and corners; the pilot light is easily lit from the outside; there is an extra large drain for fat, with valve conveniently located.

Any number of fryers can easily be connected because of special manifold construction.

A Portable Combination Operating Light and Moving Picture Unit

In a portable combination operating light and moving picture unit now on the market there is presented an instrument that makes it possible for the surgeon to see himself work. He can also keep records of his interesting cases and can have his own library of pictures that will be valuable for reference and research purposes. This recently perfected instrument simplifies the taking of moving pictures of surgical work, eliminating guesswork.

According to the manufacturers, it gives the surgeon a better, cooler light under which to work, a variable light that can be adjusted to any height, angle or position and to any degree of intensity. The surgeon thus secures



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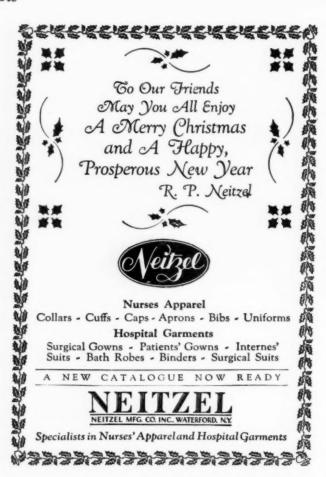
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NORINKLE



Are Used in Every Hospital Where Economy and Comfort of the Patient Are Considered

The NORINKLE Rubber Sheet is just what the name implies, a rubber sheet so made that it cannot wrinkle and cause discomfort to the patient. And because it does not wrinkle it cannot crack and become useless. The comfort of your patient is an important responsibility while long life and mattress protection are important economy considerations. You get these, and more, in NO-RINKLE Rubber Sheets.

Write for Catalog "A"

HENRY L. KAUFMANN & CO. 301 Congress St., Boston, Mass.

clear pictures of his every move from his same angle of observation. With the telescopic lens the field of observation can be enlarged two or three times without moving the camera. In one second, the field of observation can be changed. Cameras with single lens—2-inch—for operations make an excellent combination.

The field of observation of the camera is observed in the mirror at the rear of the camera view finder when the back peep sight is removed. What the light spot covers, the camera takes. A patented rewind and spring control mechanism controls the camera action from behind the doctors and nurses. The surgeon himself can start or stop the camera by a single bulb or button action conveniently located. For longer exposures on internal work, reduction of the speed of the camera is controlled by friction on the lower rewind wheel.

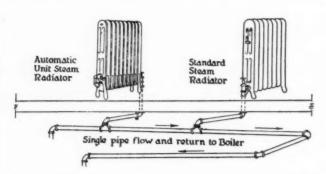
No special technical skill or knowledge of movie photography is required.

The machine may be easily moved from one room to another, or from one position to another. The entire unit is finished in nickel chrome plate.

An Automatic Gas-Steam Radiator as an Auxiliary Heating Unit

An improved automatic gas-steam radiator used as an independent auxiliary heater or in combination with a centrally fired steam or hot water heating system seems excellently adapted for institutional use.

Its application definitely solves two problems that constantly confront the hospital administrator: How can one room or section be heated satisfactorily for a limited time without the necessity of using the entire heating plant? How can a considerably higher temperature be obtained and controlled in one room or section than is necessary in the balance of the building? To justify the utility of the radiator it is necessary to mention but a few practical



instances in which such questions arise. There are certain days in the Spring and Fall when it is absolutely essential to maintain some type of heat in examining rooms, in dressing rooms, in nurseries, in physical-therapy departments and in playrooms in excess of the temperature that exists throughout the rest of the institution.

In any building provided with a steam heating system, centrally fired, there will be a drop in the general temperature to approximately 50° F. after a certain hour at night. This is due to the "banking" of the fires. Windows in patients' rooms and employees' sleeping quarters will be open. Often it is necessary to use one room or a section of a building in which a temperature of at least 68° F. is required. The night clinic, the medical staff meeting rooms, the board room, the superintendent's office, the night superintendent's office, one room in the laboratory

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GOOD SAMARITAN HOSPITAL CINCINNATI, OHIO

TAKE note of this marvelous institution—Beautiful, modern and CLEAN. Of all the virtues that the present day hospital must possess cleanliness is one of the most important. Cleanliness of surroundings is quickly reflected in cleanliness of personnel.

MIDLAND TILEOLEUM

THE PERFECT CLEANSER

for tile, marble, terrazzo and similar surfaces is keeping thousands of hospitals spotlessly clean with a minimum of labor and cost. Tileoleum is a Midland Perfected Product designed for this work and is offered to hospitals after laboratory work has proven its merits.

May we demonstrate in your hospital without obligation or cost to you?

MIDLAND CHEMICAL LABORATORIES, INC. DUBUQUE, IOWA, U.S.A.

Patients' spirits rise in leaps

-when you serve a dish like this

Bacon and Baked Oysters with Cream of Wheat

2 cups cooked Cream of Wheat Salt and pepper 1 pint oysters 4 thsps. melted butter Bread crumbs

Combine Cream of Wheat and oysters. Season. Sprinkle with buttered crumbs and bake in a moderate oven 30 minutes. Serve with broiled bacon.

JUST a whiff of it, coming down the corridor brings a gleam of interest to lack lustre eyes. Patients who have been lying weakly against

the pillows . . . whose feeble voices have been decrying "nourishment" . . . are apt to straighten up with a good normal jerk and talk right out, enthusiastically, about "food" when this dish

makes its entry.

In the first place, it just isn't a "sick looking" kind of meal. Oysters themselves waken all sorts of pleasant memories. Crisp, curly strips of brown bacon add fragrance and flavor and accent.

The binder of the whole delectable concoction -hot, buttery, browned to a turn-is that cereal standard in every hospital - Cream of Wheat. The ingenious dietitian who's contrived such a dish, as well as the uniformed diplomat who serves it, knows that Cream of Wheat is invaluable as a base in invalid cookery. It is so rich in carbohydrate content, so easy to digest and soothing to alimentary tracts not yet quite up to par.

When routine palls, reach for the Cream of Wheat carton. It is triple-wrapped and triplesealed-you'll never have trouble with contamination. And each package holds forty generous servings at less than one cent each. Here's every incentive for a dietitian to wax adven-

turesome.

FOR THIRTY-THREE YEARS A STANDARD FOOD ON PHYSICIANS' DIET LISTS

The Cream of Wheat Corporation Minnesota Minneapolis

for night emergency examinations and the night admitting room or any inactive sedentary post are a few of the sections that periodically call for additional heat. It is poor economy to heat an entire isolation pavilion for one patient when another satisfactory type of heat can be procured.

The answer to all this is the application of the gassteam radiator. A gas-steam unit in these rooms is substituted for standard direct radiation. supply line may be led into the gas-steam unit, so that while steam is supplied from the boiler the gas-steam unit will take that steam and function as a standard When the fires are banked and the pressure drops, the steam valve is turned off and the gas burner in the radiator is lighted. As long as may be required, the gas-steam radiator will maintain its independent pressure in the unit and may be turned on or off at will to govern the desired temperature. The unit can be equipped also with an automatic room temperature control.

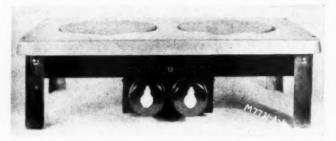
It frequently occurs that additions are made to an existing structure when the original calculations for heating have not provided for more than the normal reserve in the boiler rating. In such cases it is not feasible to furnish additional radiation from the main source of supply. This situation can be handled by installing gassteam radiation, which is independent of the existing heating plant.

The gas-steam radiator is made of cast-iron and externally it is constructed like a standard steam radiator. The manufacturers claim that it is practically odorless and that it does not produce by itself any by-product of combustion or injurious gases. To the casual glance the gas-steam radiator is not distinguishable from any standard steam radiator.

Improved Hot Plate Has Place in the Diet Kitchen

A new, improved hot plate that promises to improve the efficiency of cooking operations is now being dis-

The manufacturers have this to say of the hot plate: "The very appearance of this hot plate speaks of those



other qualities that give it a long life in the hardest kind of service-ease and economy in operation."

The base is of heavy steel, black japanned. The legs and top are finished in chromium plate, nonrusting, nontarnishing, easy to keep clean. The two 8-inch enclosed heating units are controlled by three-heat switches mounted on the front of the appliance. Each of the units has a capacity of 1,800 watts. When operated at "high" heat, they glow red. The units are protected for long life and are also easy to keep clean.

The hot plate has been designed by the manufacturers to meet present day commercial and industrial needs. The appliance is valuable in the hospital kitchen.

MODERN **ECONOMICAL**

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EFFICIENT CONVENIENT

HE Subveyor has today proved its value in the unique problems of hospital food service and dish handling. A number of waste of china breakage, and installations, both large and small, have confirmed its utility in doing a better job for the hospital than any other known device or method.

Primarily the Subveyor is making the hospital

Write for descriptive literature, or let us arrange for a personal consultameal hour a period of s mooth orderliness.

Again, it is economical cutting down on the need for surplus equipment, reducing the

conserving useful space. And again, it is convenient—enabling the personnel, the nurse and the dietitian to perform their duties with the highest of effectiveness.

The Subveyor offers numermodern-antiquating many ex- ous merits. Any of them and all isting systems and revealing a of them will appeal to the supernewer and finer order. Again, it intendent and the architect. It is efficient—eliminating a world is a time-saver and a moneyof excess time and labor and saver, and above all it allows

> for a truly remarkable standard of service to be maintained.

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KOTEX



MATERNITY PADS



KOTEX ... Regular

. . . should be in use in your hospital BECAUSE—

1 They are made of Cellucotton Absorbent Wadding—the most active absorbent known—combined with Curity Surgical Gauze.

2 They are the most widely known sanitary napkins in the world. Patients have a feeling of security when products of recognized quality and reputation are used.

3 Large increases in the use of these products by hospitals has put production on a larger scale . . . resulting in lower manufacturing costs. These are reflected in the form of extremely attractive prices.

⁴ The reasonable price of Kotex Maternity Pads makes ready-made maternity pads in *any* hospital an obvious economy.

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